

# Development Assistance for Health: Stakeholder perspectives on emerging donors in sub-Saharan Africa

## **Inauguraldissertation**

zur  
Erlangung der Würde eines Doktors der Philosophie  
Vorgelegt der  
Philosophisch-Naturwissenschaftlichen Fakultät  
Der Universität Basel

von

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von Vereinigte Staaten von Amerika

Basel, 2019

Genehmigt von der Philosophisch-Naturwissenschaftlichen Fakultät

auf Antrag von

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Basel, 13 Dezember 2016

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## Table of Contents

Acknowledgements .....	iii
Summary .....	v
List of Tables .....	ix
List of Figures .....	xi
List of Abbreviations .....	xiii
1. Introduction .....	1
1.1 Changes in landscape of development assistance for health .....	1
1.2 Private assistance .....	11
1.3 Support from emerging economies .....	20
1.4 The Global Fund .....	31
1.5 Donor darlings and orphans .....	36
1.6 Rationale for thesis .....	38
2. Aims and Objectives .....	39
2.1 Aims .....	39
2.2 Objectives .....	39
3. Summary Methods .....	41
3.1 Study areas .....	41
3.2 Primary data collection .....	49
3.3 Analysis .....	51
4. Stakeholder perceptions in sub-Saharan Africa of private assistance for health and principles of aid effectiveness .....	53
4.1 Abstract .....	54
4.2 Introduction .....	55
4.3 Methods .....	57
4.4 Results and Discussion .....	60
4.5 Conclusion .....	71
4.6 Key messages .....	72
4.7 Acknowledgements .....	72
5. Engaging with emerging economies for health development: a case-study of four sub-Saharan African countries .....	75
5.1 Abstract .....	76
5.2 Introduction .....	77
5.3 Methods .....	79
5.4 Results .....	82
5.5 Conclusions .....	95
5.6 Take-home messages .....	96

5.7	Acknowledgements .....	96
6.	The Global Fund's paradigm of oversight, monitoring, and results in Mozambique .....	97
6.1	Abstract .....	98
6.2	Introduction .....	99
6.3	Methods .....	103
6.4	Results and Discussion .....	105
6.5	Conclusion .....	122
6.6	Take-home messages .....	122
6.7	Acknowledgements .....	123
7.	Discussion .....	125
7.1	Synthesis .....	125
7.2	Overall significance of research .....	127
7.3	Limitations .....	129
7.4	Recommendations and Future Research .....	130
8.	References .....	135
9.	Annex .....	151
9.1	Annex 1. Semi-structured interview guide (for health ministry officials) .....	151
9.2	Annex 2. Non-BRICS emerging economies' activities in-country .....	153
10.	CV .....	157

## Acknowledgements

First I would like to thank my supervisor, Don de Savigny, for his continuous and kind support without which this project would not have been possible. His welcoming support enabled me to overcome every obstacle and complete this work.

Our dear Marcel Tanner. Our fearless leader. Thank you. Thank you for always taking the time to meet with me, to talk through my concerns, and for sharing your insights and resources at every opportunity. Thank you for your generosity, humor and levity. You taught me invaluable lessons about approaching every situation with an openness of mind and spirit.

I cannot thank Christine Mensch enough for her support and friendship over the years. She became part of my family-away-from-family. Our Friday afternoon chats were something that I always looked forward to and missed whenever I was abroad.

Margrith Slaoui and I spent more time on the phone in the past few years than I did with most friends. I thank her for all the laughs and her patience while we ironed out the details of project administration. She is an integral part of my Swiss TPH experience.

I would like to thank my collaborators in this research Ilona Kickbusch, Shufang Zhang, Stephen Browne, Raymond Saner, and Lichia Yiu. Michaela Told and Roberto Cordon, I especially appreciate the time that you took to provide extra guidance. Michaela, thank you for your support and for the additional diplomacy lessons. Roberto Cordon, thank you for your dedication while I prepared manuscripts.

I would like to thank our gracious hosts for their support in Chad, Ghana, and Tanzania, respectively: Dr Daugla Doumagoum Moto (Centre de Support en Santé Internationale; N'Djamena, Chad), Dr. Moses Aikins (University of Ghana; Accra, Ghana), and Dr. Honorati Masanja (Ifakara Health Institute; Dar es Salaam, Tanzania). I would especially like to thank Dr. Charles Mayombana for being such a helpful guide in the halls of the Ministry of Health and on the streets of Dar es Salaam. Malaba Haroun, thank you for patiently translating interviews, the lively discussions, and mini French lessons between appointments. I know that I always have a friend in N'Djamena.

Vreni Jean-Richard, Helena Gräter, and Monique Lechemmen, thank you for showing me around N'Djamena, teaching me to tell the moto drivers “doucement”, and introducing me to

your Chadian families. I would also like to thank Andre Madchila for welcoming to Maputo and arranging such a comfortable home in Maputo. Carolina Kwok, thank you for hosting me and making my time in Dar es Salaam very lively.

I would like to thank ALL of my officemates and hallmates for making daily at Swiss TPH so pleasant.

I cannot thank my family and friends enough for their ceaseless support. These relationships are my greatest blessing.

Finally I would like to thank the Swiss Network for International Studies and the Swiss Tropical and Public Health Institute for funding this project.

## Summary

The architecture of development assistance for health (DAH) is increasingly complex with the arrival of new actors, particularly from the private sector, emerging economies, and global health initiatives. Prior to the year 2000, development assistance for health was funded by OECD bilateral and multilateral agencies and led by global expert and governance institutions in the United Nations (UN). Agendas, strategies, and interventions evolved but remained under the umbrella of relatively few financing mechanisms. In 2000, global consensus to support the Millennium Development Goals (MDGs) dramatically altered the global health financing landscape and sparked accelerated growth in DAH. More than 100 global health initiatives were created, and private donors- including philanthropic foundations and corporate social responsibility programs- contributed to unprecedented levels of DAH.

The rise of the so-called BRICS countries (Brazil, Russia, India, China, and South Africa) has provided one more element of change in the landscape of global health and global health financing. Due to improved governance and globalization of trade and technology these countries, along with other emerging economies, are experiencing remarkable economic expansion. Many have shown commitment to development cooperation and have provided health assistance to developing countries.

Overall, DAH has plateaued since 2010, and it remained steady for four consecutive years. In 2014, it decreased for the first time. Although growth of DAH resumed, it has slowed and isn't projected to increase in the coming years.

Global monitoring of financial flows for DAH as part of Official Development Assistance (ODA) includes traditional Organization for Economic Co-operation and Development – Development Assistance Committee (OECD DAC) sources and fails to include these pivotal new actors, their programme activities, and their influence. The limitations of the ODA tracking system are growing due to the gap in data from providers of ODA. There is increasing influence outside of the OECD DAC, but, to date, the magnitude of *unofficial* development assistance is unclear.

Shared roles and responsibilities blur the division among traditional and emerging donor aims and responsibilities. This raises concerns about legitimacy, accountability, and international cooperation as well as concerns over potential conflicts of interest, divergence from national strategies, and lack of harmonization among donors. The influence of increasing plurality of

the global health financing system on the coherence, efficiency, and effectiveness of health development programmes requires further investigation.

A growing proportion of development assistance for health comes from unofficial sources and therefore isn't tracked or properly evaluated. Although many emerging donors have expressed support for international aid effectiveness principles, the influence of their support at country-level and their level of adherence to international guidelines has been unclear.

This thesis aims to contribute to the literature on development assistance for health and the influence of emerging donors for health, specifically the Global Fund, philanthropic foundations, corporate social responsibility, and emerging economies. It focuses on in-country perceptions of the successes and challenges of working with these partners in Chad, Ghana, Mozambique, and Tanzania- four countries that span the donor-darling / donor-orphan spectrum. Each of the four case-study countries has a different existing relationship with providers of official development assistance to health. It was unknown if the trends are reflected in relationships with new donors or if donors who act outside of official development assistance channels establish their own unique norms.

In terms of private finance, respondents in the case-study countries conclude that the small-scale engagement of private donors makes them complementary to large bi- and multi-lateral agencies. They are not foreseen to become the predominant providers of health assistance. Private donors are not necessarily aligned with country priorities or strengthening country health systems and currently contribute to fragmentation due to their narrow focus. Their small-scale engagement makes harmonization more difficult AND more necessary, but private actors are absent in coordination groups at the country-level. Overall, country-level discussions still focus on alignment and harmonization of development assistance for health. Although the international community has updated aid effectiveness principles, the Paris Declaration is still the framework in-country ten years later.

Country-level discussions on emerging economies highlight that the BRICS countries are not the only emerging economies visible in the health sector of sub-Saharan African countries. Similar to private actors, the emerging economies are not seen as a potential replacement, but rather as a supplement, for traditional aid. They are primarily focused on investment opportunities. Overall, due to emerging economies' lack of coordination, health development partners in-country are not well-informed of health-specific engagement. Some government



officials welcome this unconventional engagement while development partners can be sceptical of the sustainability and the implications for the social welfare of citizens in recipient countries.

The Global Fund is an example of an emerging donor credited with great successes, even compared to traditional bi- and multilateral agencies. In Mozambique respondents see the Global Fund's ability to reform as unique for such a large organization and perceive its approach to be continually evolving. That said, respondents believe that there are many challenges that remain after its recent reform. The lack of a country office has many negative downstream effects including over-reliance on in-country partners. Partnerships provide much needed support for Global Fund recipients, but roles, responsibilities, and accountability must be clearly defined for a successful long-term partnership. Although the Global Fund emphasizes coordination at the higher levels of the organization, the country teams' engagement with other actors is not formalized and is often inadequate.

In conclusion, we found that private donors and emerging economies are not often not held to the same standards as conventional donors in terms of regulation and policies. This culture of more relaxed standards begs for more stringent transparency measures. Transparency of emerging donors' financial flows is not only important for understanding the volume of assistance these actors provide, but also to mitigate potential corruption.

This is especially important in light of recent trends in the volume of DAH. Official development assistance for health has shown volatility in recent years, and emerging donors may find themselves playing a larger role than they had originally anticipated. The development community has adapted to the global financial crises, but soon it may be faced with shortages due to political crises in OECD countries. Brexit, the recent US presidential election, and predictions about upcoming French and German elections all highlight a widespread nationalist trend that, among other consequences, could directly affect bilateral assistance programs. This places even more importance on developing best practices and increasing inclusivity in aid effectiveness fora.



## List of Tables

Table 1. OECD DAC members .....	2
Table 2. Indicators for the four dimensions of aid quality (Center for Global Development) ..	11
Table 3. Flows of global health financing, 2013 .....	12
Table 4. Members and associates of netFWD, 2016 .....	15
Table 5. Non-DAC countries captured in OECD statistics .....	20
Table 6. BRICS comparative indicators .....	22
Table 7. Voting constituencies of the Global Fund Board .....	32
Table 8. Top 10 development assistance for health countries, by data source (2012) .....	37
Table 9. Bottom 10 development assistance for health countries, by data source (2012) .....	37
Table 10. Case-study countries: selected comparative indicators .....	43
Table 11. Case-study countries: selected health financing indicators .....	44
Table 12. Top 5 sources of disbursements for health, case-study countries (2009-2010) .....	48
Table 13. Interviewees by institution .....	50
Table 14. Interviewees by institution .....	58
Table 15. Summary of private donors' adherence to the five Paris Declaration pillars .....	69
Table 16. Interviewees by institution .....	81
Table 17. Strengths and challenges of engagement with emerging economies .....	83
Table 18. BRICS support in case-study countries .....	92
Table 19. Interviewees by representation .....	104
Table 20. Summary of country-level perceptions of the Global Fund's paradigm .....	120
Table 21. Research findings within the Swiss TPH research pillars .....	128



## List of Figures

Figure 1. Changes in DAH landscape .....	1
Figure 2. DAH by channel in 1990 and 2011, respectively .....	5
Figure 3. Sources of DAH 1990-2015.....	6
Figure 4. Country contributions to neglected disease research and development.....	8
Figure 5. Flows of global health financing, 2013.....	13
Figure 6. Percent change in DAH sources, 2004-2015 .....	17
Figure 7. BRICS annual GDP growth, 2005-2015.....	24
Figure 8. Development finance from non-DAC providers reporting to OECD, 2000–2013 ...	30
Figure 9. Global Fund replenishments .....	33
Figure 10. Quality of Global Fund assistance, 2014 .....	35
Figure 11. Map, case-study countries.....	41
Figure 12. ODA for health per capita, disbursements .....	45
Figure 13. External resources for health (percent of total expenditure).....	47
Figure 14. Non-BRICS emerging economies engaged with case-study countries.....	93
Figure 15. GDP growth (annual, %), emerging economies active in case-study countries .....	94
Figure 16. Comparison of the Rounds-based funding process and the New Funding Model	102



## List of Abbreviations

AfDB	African Development Bank
BMGF	Bill & Melinda Gates Foundation
BRICS	Brazil, Russia, India, China, and South Africa
CCM	Country Coordinating Mechanism
CPTF	Comité des Partenaires Techniques et Financiers
CSR	Corporate Social Responsibility
DAC	Development Assistance Committee
DAH	development assistance for health
DfID	UK's Department for International Development
DNDi	Drugs for Neglected Diseases
EU	European Union
FDI	foreign direct investment
GAVI Alliance	the Global Alliance for Vaccination and Immunization
GDP	gross domestic product
GH	Ghana
GHI	Global Health Initiative
GHS	Ghana Health Service
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HSS	health system strengthening
IATI	International Aid Transparency Initiative
IBRD	International Bank for Reconstruction and Development
IHI	Ifakara Health Institute
IHME	Institute for Health Metrics and Evaluation
IMF	International Monetary Fund
JICA	Japan International Cooperation Agency
KOICA	Korea International Cooperation Agency
LFA	Local Fund Agent
MDG	Millennium Development Goal
MMV	Medicines for Malaria Venture
MoF	Ministry of Finance
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding
MZ	Mozambique
netFWD	Global Network of Foundations Working for Development
NFM	New Funding Model
ODA	official development assistance
OECD	Organization for Economic Co-operation and Development
PDP	product development partnership
PEPFAR	the US President's Emergency Plan for AIDS Relief
PMI	the US President's Malaria Initiative
PMO-RALG	Prime Minister's Office - Regional Administration and Local Govt
PPP	public-private partnership
PR	Principal Recipient
SDC	Swiss Agency for Development and Cooperation
TD	Chad

TZ	Tanzania
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank
WHO	World Health Organization

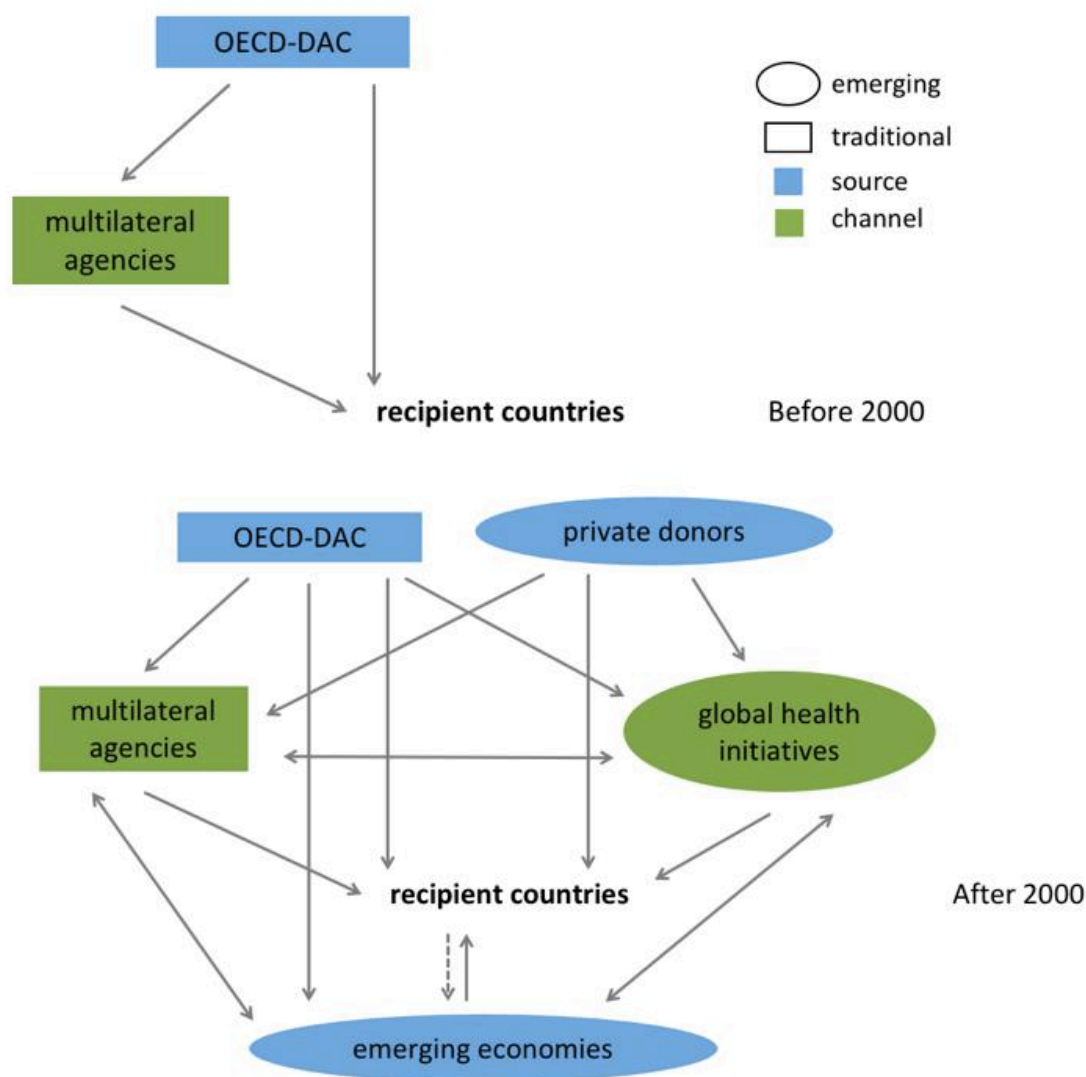


## 1. Introduction

### 1.1 Changes in landscape of development assistance for health

The architecture of development assistance for health (DAH) is increasingly complex with the arrival of new actors, particularly from the private sector, emerging economies (Kickbusch and Szabo, 2014), and global health initiatives (Figure 1). This is coupled with the decline in influence from the conventional global health leadership of the United Nations System. Global monitoring of financial flows for DAH as part of Official Development Assistance (ODA) continues to focus on conventional OECD (Organization for Economic Co-operation and Development) sources and fails to include these pivotal new actors, their programme activities, and their influence (OECD, 2016g).

Figure 1. Changes in DAH landscape



The OECD development assistance committee (DAC) (Table 1) defines ODA as assistance from official or executive agencies to multilateral institutions and countries or territories on the DAC list of ODA recipients. ODA is concessional and contains at least a 25 percent grant element. Its main objective is the promotion of economic development and welfare for developing countries (OECD, 2016h). Although ODA is defined by its recipients, the growing limitation of the ODA tracking system when trying to understand development assistance for health is actually the gap in data from *providers* of ODA. There is increasing influence outside of the DAC, but, to date, the magnitude of *unofficial* development assistance is unclear.

*Table 1. OECD DAC members*

Australia	Greece	Poland
Austria	Iceland	Portugal
Belgium	Ireland	Slovak Republic
Canada	Italy	Slovenia
Czech Republic	Japan	Spain
Denmark	Korea	Sweden
European Union	Luxembourg	Switzerland
Finland	The Netherlands	United Kingdom
France	New Zealand	United States
Germany	Norway	

(OECD, 2016c)

Prior to the year 2000, development assistance for health was funded by OECD bilateral and multilateral agencies and led by global expert and governance institutions in the United Nations (UN). Agendas, strategies, and interventions evolved but remained under the umbrella of relatively few financing mechanisms (Maciocco and Stefanini, 2008, Sridhar, 2009). In 2000, global consensus to support the Millennium Development Goals (MDGs) dramatically altered the global health financing landscape and sparked accelerated growth in DAH.

At this time some believed finance was the sole obstacle preventing the success of health development goals (Sachs, 2001). The international community vowed to increase their financial support and develop the necessary infrastructure to mobilize these resources. As a result OECD countries increased the proportion of ODA dedicated to health (OECD-DAC, 2009, Piva and Dodd, 2009). DAH grew annually at 5.4 percent from 1990 to 2000 and 11.3 percent annually from 2000 to 2010 (IHME, 2015).

This call for massive aid injections required private financiers to increase their involvement. Overall, private capital flows are now the largest portion of financial flows from developed countries to developing countries (Miller and al., 2011), but it is unclear how much of this from

remittances, philanthropic groups, and other capital resource transfers motivated by development concerns, and how much of that is DAH.

Since 2000, the DAH arena has also become increasingly crowded by the establishment of over 100 relatively well-endowed global health initiatives (GHIs), each focused vertically on single disease or single intervention strategies such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the GAVI Alliance (Samb et al., 2009). They were designed to overcome private market and public failures in global public health. They also had the effect to disperse the power of the UN and its agencies (Hein and Kickbusch, 2010a, Buse and Walt, 2000) (Figure 2).

Public funding for GHIs was in part shifted from financing that would normally be available to the World Health Organization (WHO). This has resulted in a WHO that has become increasingly dependent on extra-budgetary sources (i.e. voluntary donations and development agencies of member states) rather than core funding and therefore less in control of its own agenda and experiencing diminishing credibility as a multilateral leader or driver of global health strategies (Shah, 2001, Sridhar, 2009). These changes in financing led to a more disease-specific global health agenda within the WHO which complemented the vertical programming of GHIs (Sridhar and Tamashiro, 2009). At the operational level, these problems are currently reflected in unclear definitions, roles, and implementation responsibilities leading to inefficiencies in health planning at global, national and sub-national levels.

Although global health initiatives have become the archetype for development assistance for health at country level, there is notable growth in the number of major philanthropic foundations with the Bill and Melinda Gates Foundation (BMGF) as the predominant example. Furthermore, businesses and corporations have developed corporate responsibility programmes, and there are spontaneous individual contributions to humanitarian emergencies, drug donation programmes, and international aid campaigns (Stoianova, 2012). While private financing for health has increased greatly over the last decade there is evidence of extreme volatility in both private and public ODA financial flows (Addison et al., 2005). The extent of private-DAH volatility is unclear.

DAH has plateaued since 2010, and it remained steady at approximately US\$35 billion for four consecutive years. Notably, DAH decreased for the first time in 2014 (-1.6 percent relative to 2013) (Figure 3) (IHME, 2015). Least developed countries had a particularly pronounced

reduction in ODA in 2011 and 2012. Bilateral aid to sub-Saharan Africa, where many of the poorest countries are located, decreased about five percent in real terms in 2014 (UN, 2015).

Although growth of DAH resumed, it slowed, and any growth was primarily attributable to one actor: the International Bank for Reconstruction and Development (IBRD) (IHME, 2011, Leach-Kemon et al., 2012), a trend which may continue under its new president. Simultaneously, in 2011, key bilateral donors such as the United States slowed the growth of their assistance, the UN ceased its growth, the Global Fund retracted its call for the next round of proposals (Leach-Kemon et al., 2012), and researchers suggested reforms for the World Bank and the International Monetary Fund (Woods, 2009). Additionally, health spending in countries that borrow from the International Monetary Fund (IMF) grew at half the speed of non-borrowers (Stuckler et al., 2011b).

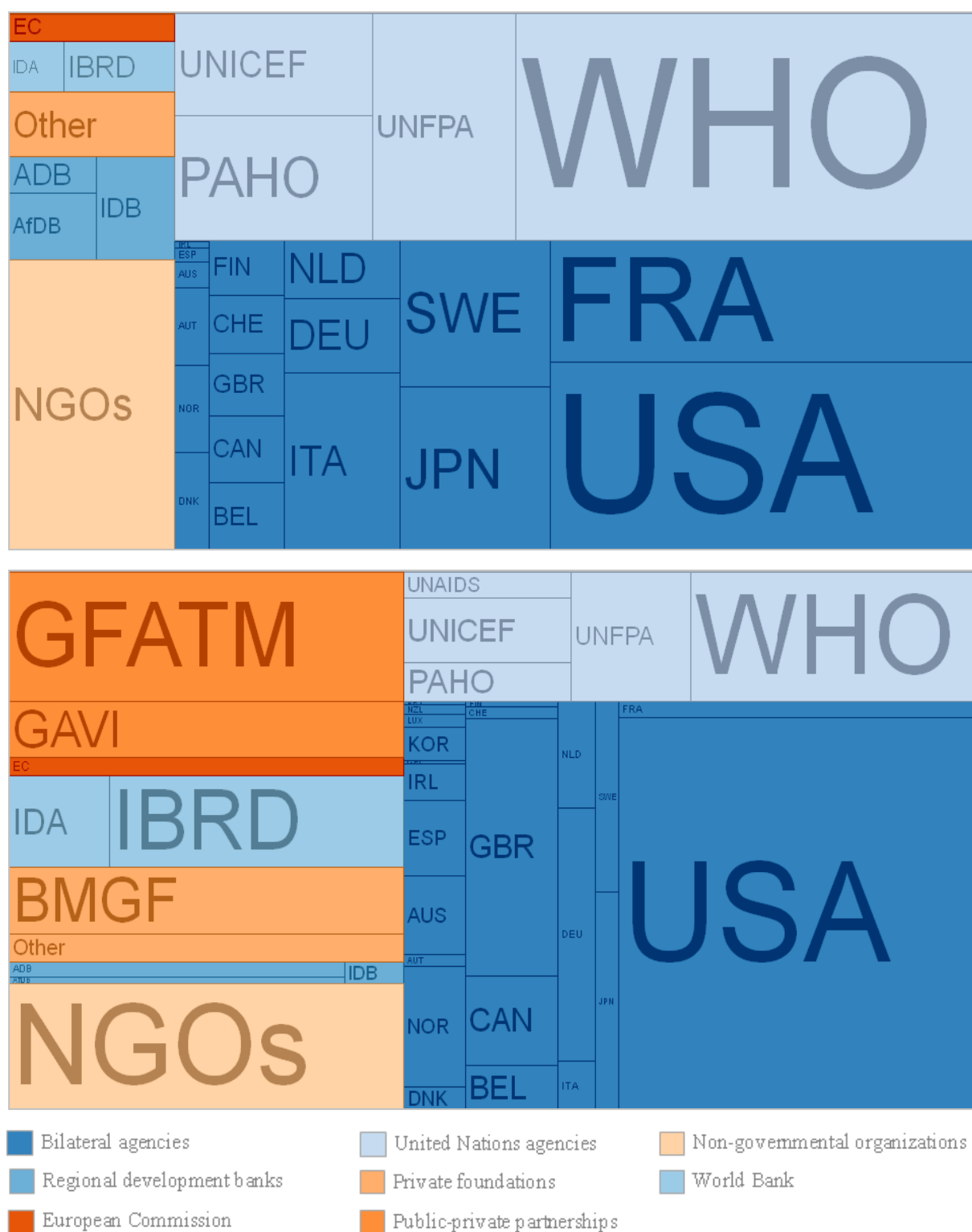
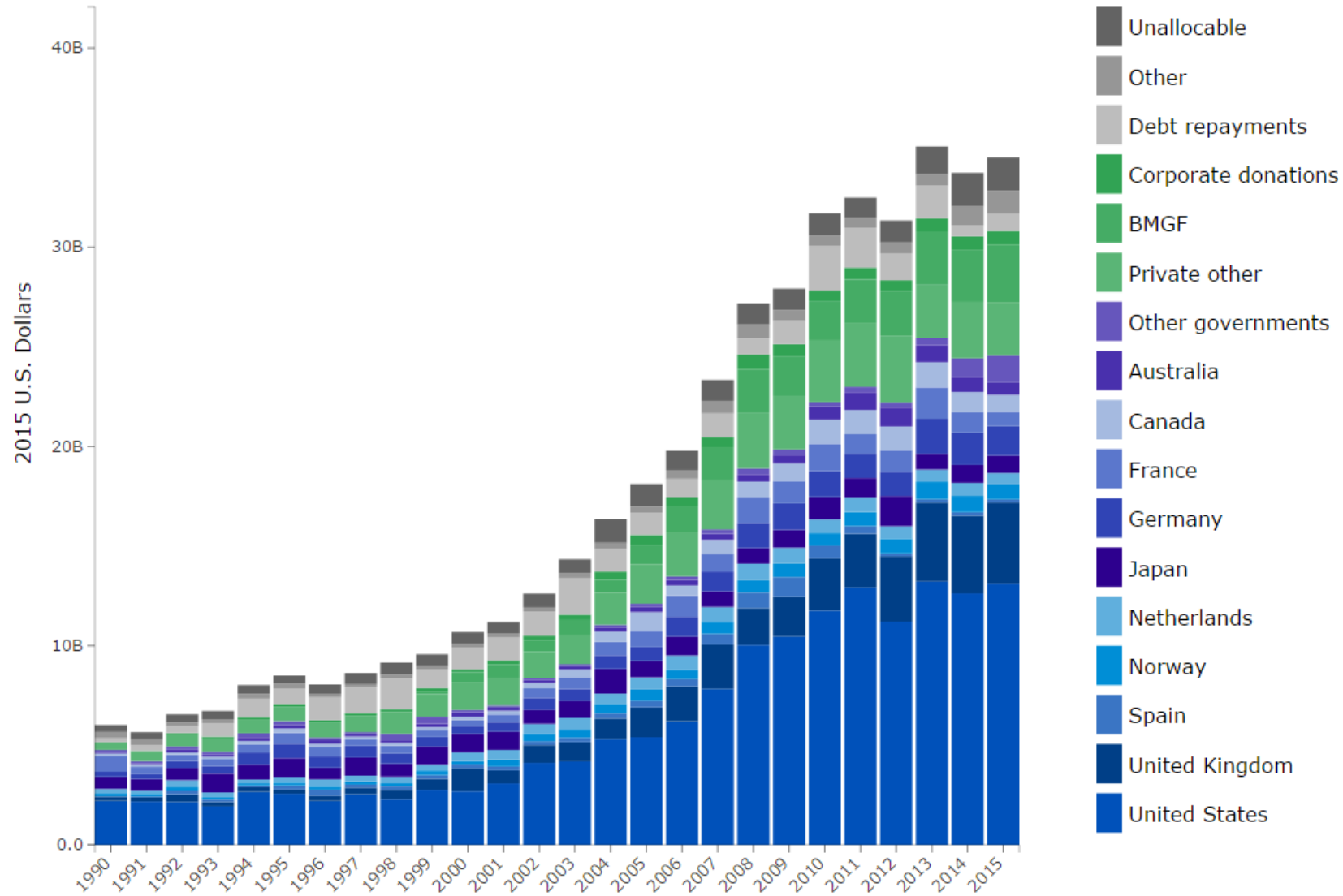


Figure 2. DAH by channel in 1990 and 2011, respectively (IHME, 2016)



*Figure 3. Sources of DAH 1990-2015*  
(IHME, 2016)

The rise of the so-called BRICS countries (Brazil, Russia, India, China, and South Africa) has provided one more element of change in the landscape of global health and global health financing (Figure 4) (Ponder and Moree, 2012). Due to improved governance and globalization of trade and technology these countries are experiencing remarkable economic expansion (USAID, 2012). At a combined 40 percent of the global population, (Maia et al., 2012) BRICS health financing, both at domestic and international levels, is vital for achieving health development goals.

In 2015 China was the second largest global economy with India and Brazil seventh and ninth, respectively (IMF, 2016). These countries have increased their position as potential donors by participating in myriad international organizations and international financial consortia such as the G-20 (Bliss et al., 2010). They have also investigated more formal South-South collaborations and partnerships (Maia et al., 2012, Stuckler et al., 2011b, Sridhar, 2009, Tytel et al., 2012), and at some points in the last decade their development assistance has grown 10 times faster than conventional OECD donors (Tytel et al., 2012, Birdsall, 2012b).

Global health diplomacy discussions call for a research agenda that illuminates the role of non-state actors, the interactions between conventional and unconventional actors, and how global health diplomacy can enhance collective action (Lee and Smith, 2011, Fidler, 2009, Farag et al., 2009). Continual creation of new organizations, rather than strengthening and coordinating those that exist, presents a challenge to effective DAH (Sridhar, 2010, de Renzio, 2011, Woods, 2011). Another important element of the global health diplomacy agenda is a repositioning of health in foreign policy negotiations (Labonté et al., 2011, Sridhar and Smolina, 2012).

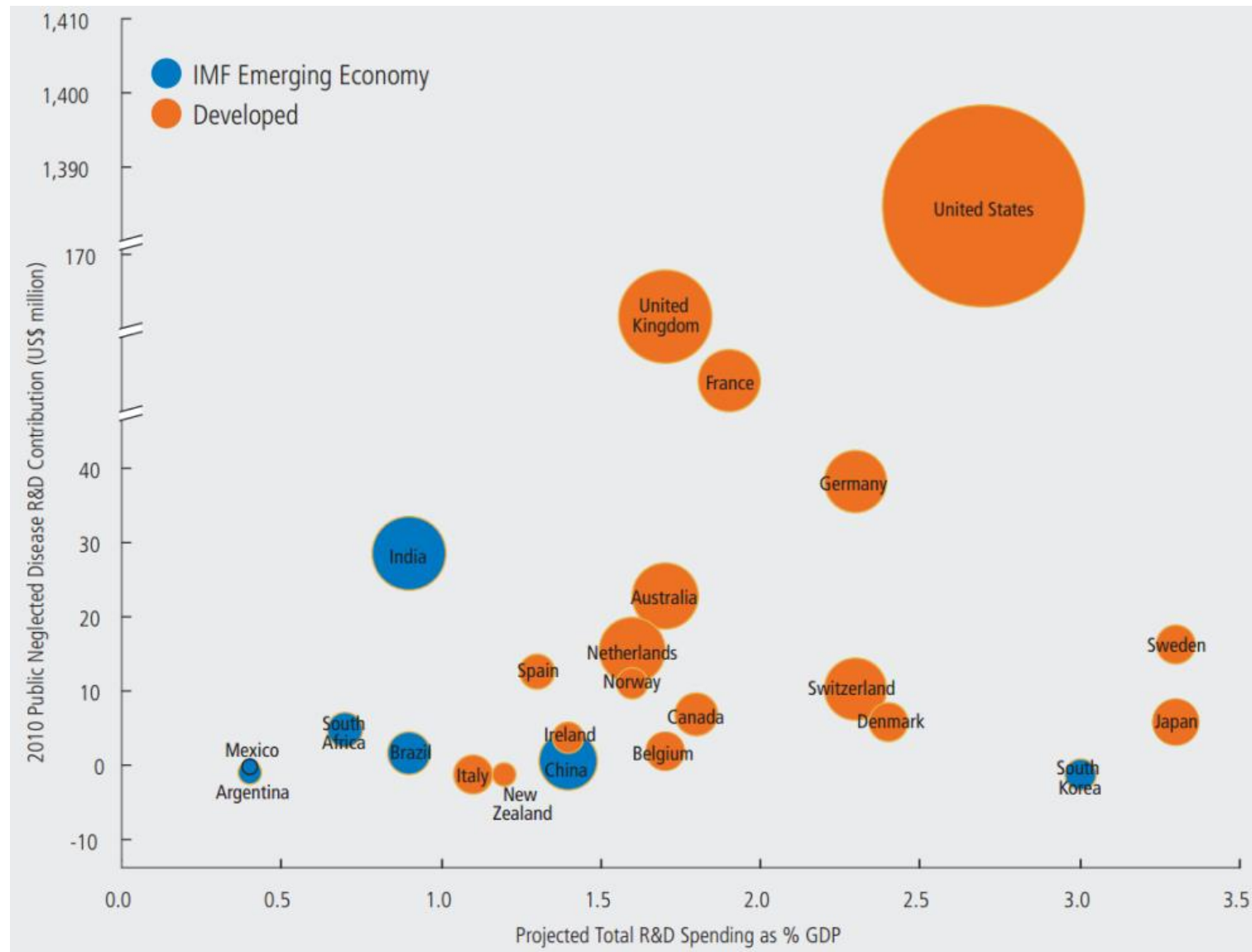


Figure 4. Country contributions to neglected disease research and development  
(Ponder and Moree, 2012)



Recent findings show that if European Union (EU) donors implemented the Paris Declaration and the Accra Agenda for Action, they would benefit by monetary gains of up to six percent of total EU ODA. This includes savings on transaction costs, gains from untying aid and reducing aid volatility, as well as other indirect effects (Prizzon and Greenhill, 2012). Both the Paris Declaration and the Accra Agenda for Action are rooted in systems thinking, and their implementation would have two important potential indirect effects: strengthened health systems and increased population health that could potentially increase the likelihood of foreign direct investment (Desbordes and Azémar, 2008) and the growth of GDP per capita (Martin et al., 2012).

Although private financiers' and BRICS' growing influence on ODA is starting to be recognized (Lanz, 2012, McCoy et al., 2009, Ravishankar et al., 2009), their influence on DAH is unknown. More recently private actors were included in high-level discussions due to the complementary role they have assumed in international development. The 2014 Global Partnership on Effective Development Cooperation High-Level meeting in Mexico was the first high-level discussion in which private stakeholders were included (Partnership for Effective Development Cooperation, 2014).

Despite the increased demand for financial tracking, members of the research community have voiced that approximately one of three dollars dedicated to health can be assigned a clearly identifiable purpose (Ravishankar et al., 2009). Much of the literature and analysis, for example, at present still neglects the impact and influence of the BRICS countries and private financing on global health development – their financial input and input in-kind is not reflected in the OECD data (McKitterick, 2012, Addison et al., 2005, OECD-DAC, 2009). This leads to significant underestimation of DAH. In years past estimates produced by the OECD and the World Bank, for example, have differed by up to approximately US\$3 billion (Piva and Dodd, 2009). Understanding the volume, nature, and influence of these new actors is vital as the development community shifts its focus to the Sustainable Development Goals.

On 25 September 2015 the UN General Assembly adopted the resolution “Transforming our world: the 2030 Agenda for Sustainable Development”, also known as the ‘Sustainable Development Goals’ (SDGs) (UN General Assembly, 2015). Whereas the MDGs had eight goals with three dedicated specifically to health, the SDGs have 17 goals with one dedicated to health- SDG Goal 3: Ensure healthy lives and promote well-being for all at all ages (UN, 2016). It has 13 targets and 16 proposed indicators (WHO, 2016d).

Despite the newly-defined goals, the MDG Gap Task Force does not predict further significant increases in official country programmable aid (CPA) through 2018, with CPA for Africa remaining below its peak in 2013. CPA accounts for more than half of donors' bilateral aid and is the most predictable part of ODA (UN, 2015). This worrying trend likely extends to the health sector and highlights the potentially widening gap that could be filled by emerging donors for health.

In light of future uncertainty of the volume finance and the composition of the actors involved, evaluating the effectiveness of assistance becomes increasingly important. In their most recent report on the quality of official development assistance (QuODA), the Center for Global Development included non-DAC actors and the BMGF. The data on these actors is incomplete and does not allow for adequate analysis but begins to examine differences between conventional and emerging donors. The QuODA includes 31 indicators across four dimensions (Table 2).

*Table 2. Indicators for the four dimensions of aid quality (Center for Global Development)*

<b>Maximizing efficiency</b>	<b>Fostering institutions</b>	<b>Reducing burden</b>	<b>Transparency &amp; learning</b>
Share of allocation to poor countries	Share of aid to recipients' top development priorities	Significance of aid relationships	Signatory of International Aid Transparency Initiative
Share of allocation to well-governed countries	Avoidance of project implementation units	Fragmentation across donor agencies	Implementation of IATI data reporting standards
Low unit administrative costs	Share of aid recorded in recipient budgets	Median project size	Recording of the project title and descriptions
High country programmable aid share	Share of aid to partners with good operational strategies	Contribution to multilaterals	Detail of project descriptions
Focus / specialization by recipient country	Use of recipient country systems	Coordinated missions	Reporting of aid delivery channel
Focus / specialization by sector	Coordination of technical cooperation	Coordinated analytical work	Share of projects reporting disbursements
Support of select global public good facilities	Share of scheduled aid recorded as received by recipients	Use of programmatic aid	Completeness of project-level commitment data
Share of untied aid	Coverage of forward spending plans / aid predictability		Aid to partners with good monitoring and evaluation frameworks

(Birdsall and Kharas, 2014)

This framework was developed as a response to the evolving discussions on aid effectiveness and notes the importance of not just tracking dollars but examining the effectiveness of the organizations that provide finance.

## 1.2 Private assistance

Estimates for private philanthropy in 2013-2014, including corporations, charitable giving and philanthropy excluding the BMGF, approximate US\$3.4 billion for global health (IHME, 2015). Overall, private philanthropy has grown more substantially than corporate donations over the last decade (IHME, 2015). Corporations were responsible for US\$662 million (1.9 percent) of DAH. Other private sources, including charitable giving and philanthropy excluding the BMGF, amounted to US\$2.7 billion (7.4 percent) of DAH. If BMGF is included in private

philanthropy, this source category accounts for 16 percent of total DAH for 2013, making it second only to the US government (Table 3).

*Table 3. Flows of global health financing, 2013*

	Amount (billions, US\$)	%
United States	13.0	35
Other Governments	5.8	15
United Kingdom	4.0	10
Other Sources	3.6	9
Private		
Philanthropy	3.4	9
BMGF	2.6	7
Germany	1.8	5
France	1.6	4
Canada	1.3	3
Australia	0.86	2

(IHME, 2016)

The BMGF is the largest single source of private finance for global health. In 2014 alone, the BMGF accounted for 8.1 percent of total DAH and 46.6 percent of private funding flows for global health (US\$2.9 billion) (IHME, 2015). Approximately half of BMGF funds are unallocable (Figure 5). The remainder is distributed among UN agencies, NGOs and foundations, the Global Fund, GAVI Alliance, and in a few cases, countries themselves. Of non-BMGF private philanthropy, 74.8 percent was provided to NGOs in 2014 (US\$2.5 billion); UN agencies and the Global Fund also received shares.

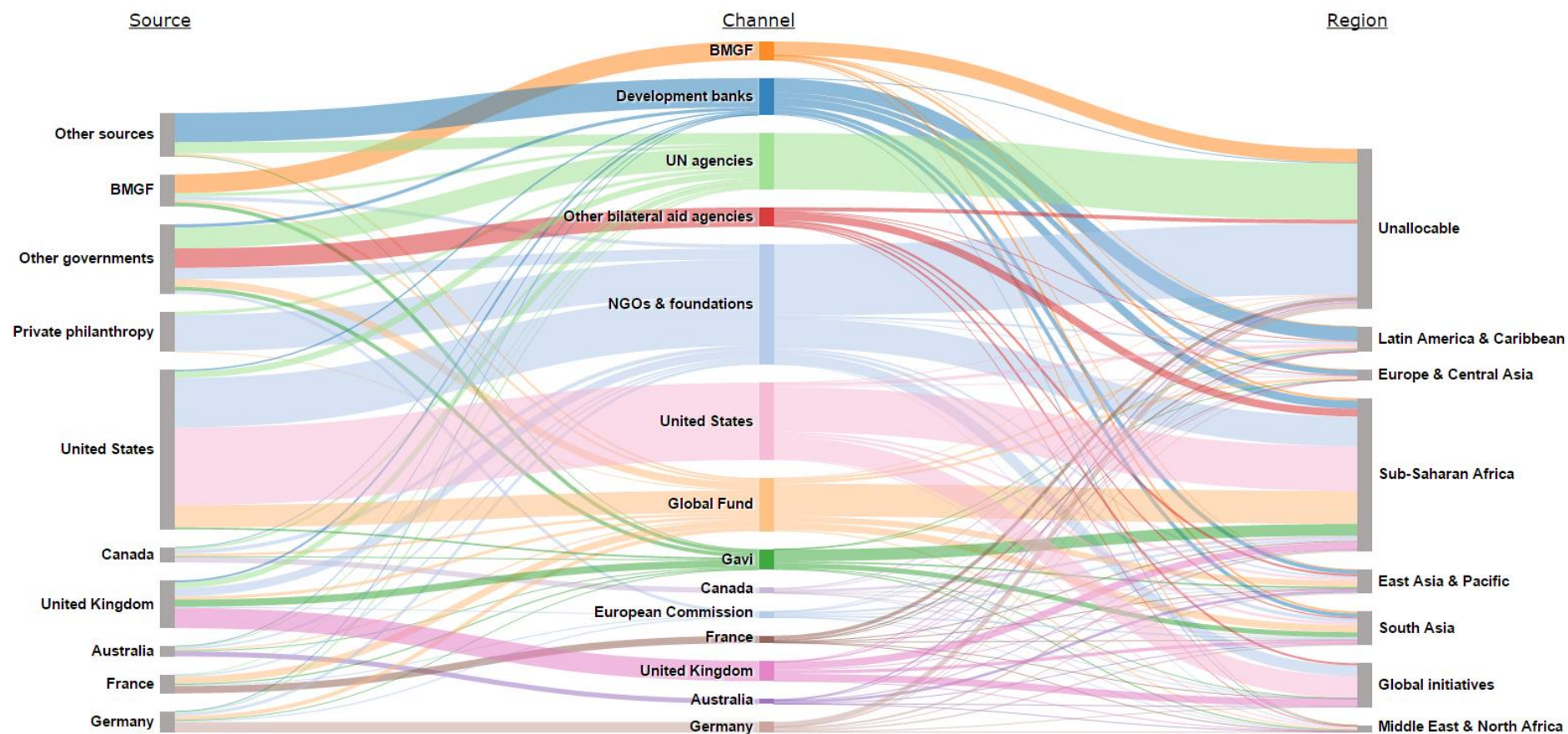


Figure 5. Flows of global health financing, 2013  
(IHME, 2016)

Development partners agreed to update the five aid effectiveness principles at the Fourth High Level Forum on Aid Effectiveness, in Busan, South Korea in 2011. This meeting marked the first acknowledgement of private actors' contribution to development (Fourth High-Level Forum on Aid Effectiveness, 2011). Analogs of the Paris Declaration pillars of ownership, managing for results, and mutual accountability were carried forward, but alignment and harmonization were replaced by "inclusive development partnerships". The most noticeable omission is language about alignment of resources with national strategies (Fourth High-Level Forum on Aid Effectiveness, 2011).

In 2012 the OECD Development Centre officially launched the Network of Foundations Working for Development (netFWD) (OECD NetFWD, 2014). This global network of foundations aims to "support foundations in their efforts to dialogue and partner with governments" to increase aid effectiveness.

The 2014 Global Partnership on Effective Development Cooperation High-Level meeting in Mexico included private stakeholders (Partnership for Effective Development Cooperation, 2014). In this same year netFWD developed the *Guidelines for Effective Philanthropic Engagement*. The three pillars- dialogue, data / knowledge sharing, and partnering- aim to foster "mutual recognition between philanthropic actors, governments and development agencies on the basis of their respective comparative advantages" (Samb et al., 2009). Essentially, this document reflects the recognition of the Paris Declaration's harmonization pillar as the foundation of effective engagement. This also suggests that all organizations associated with netFWD (Table 4) would abide by this pillar, if none other. Therefore it is surprising that the only foundation adhering to the 2011 Busan Partnership principles is BMGF (Adelman et al., 2011). Although the Busan Agreement does not explicitly address harmonization, foundations' adherence should symbolize their commitment to internationally recognized principles. Currently many philanthropic foundations neglect systematic reporting of interactions with governmental institutions and other donors operating in-country (Nam et al., 2013). Few philanthropic actors appear to be aware of the aid effectiveness principles first outlined in 2005 (OECD, 2005).

*Table 4. Members and associates of netFWD, 2016*

<b>Members</b>	<b>Location</b>
Aga Khan Foundation	Geneva, Switzerland
Bertelsmann Stiftung	Gütersloh, Germany
Emirates Foundation for Youth Development	Abu Dhabi, UAE
FHI Foundation	Durham, USA
Ford Foundation	New York City, USA
Fundação Calouste Gulbenkian	Lisbon, Portugal
Fundación Banorte	Mexico City, Mexico
Instituto Ayrton Senna	São Paulo, Brazil
Mo Ibrahim Foundation	London, UK
Novrtis Foundation	Basel, Switzerland
Sawiris Foundation for Social Development	Cairo, Egypt
Shell Foundation	London, UK
Stars Foundation	London, UK
The Rockefeller Foundation	New York City, USA
Total Corporate Foundation	Paris, France
W.K. Kellogg Foundation	Battle Creek, USA
<b>Associates</b>	
African Grantmakers Network	Accra, Ghana
Arab Foundaions Forum	Amman, Jordan
Asian Venture Philanthropy Network	Singapore
Council on Foundations	Arlington, VA
European Foundation Centre	Brussels, Belgium
European Venture Philanthropy Association	Brussels, Belgium
Foundation Center	New York City, USA
RedE América	Santiago, Chile
Worldwide Initiatives for Grantmaker Support	Manila, Philippines

(OECD, 2016f)

The most striking features of the netFWD roster are the notable lack of the BMGF, the presence of corporate actors, and the diverse geographical representation. So far the netFWD guidelines have not led to in increased financial tracking and transparency. The BMGF is the only private donor that reports to the OECD, and only American philanthropy can be traced by the US-based Institute for Health Metrics and Evaluation (OECD, 2016g, IHME, 2016).

In the report for the Third International Conference for Financing for Development in July 2015, participants acknowledged the contributions from philanthropists but called for increased transparency, accountability, and alignment with country strategies and systems (OECD NetFWD, 2014). There was no mention of coordinating efforts with these emerging actors.

Survey findings suggest that new funding partnerships contribute to philanthropic funding priorities (Missika and Romon, 2014, Foundation Center, 2016); this could increase alignment around internationally recognized goals.

Overall, shared roles and responsibilities blur the division between the private and public sectors' aims and responsibilities (Buse and Walt, 2000). This raises concerns about legitimacy, accountability, and international cooperation (Hein and Kickbusch, 2010b) as well as concerns over potential conflicts of interest (Stuckler et al., 2011a).

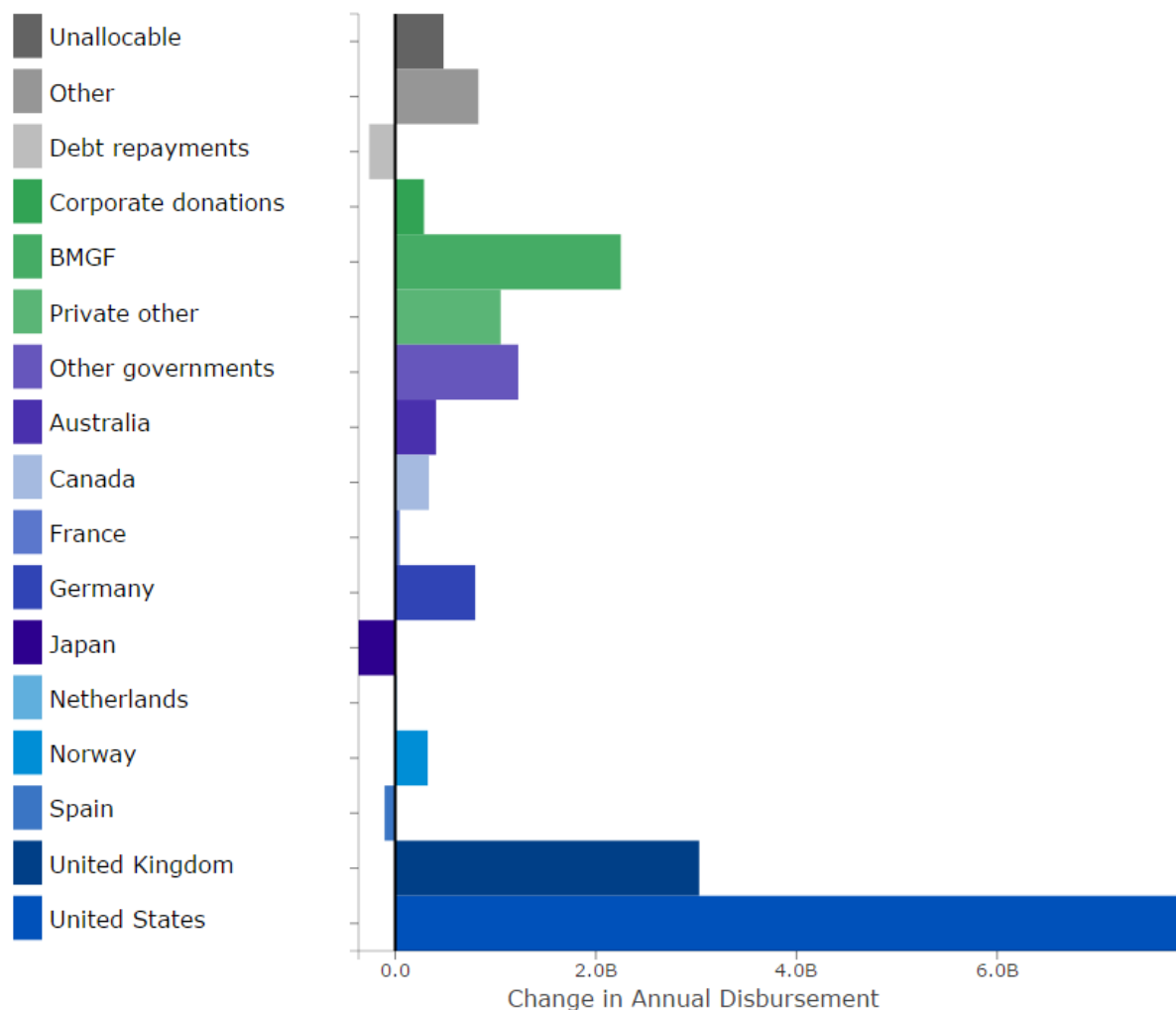
Developing best practices for private actors and an increased inclusivity of development effectiveness dialog might be even more important in the coming decades with the growing nationalist trend in Western democracies. The US presidential election outcome, Brexit, and 2017 elections in France in Germany might have direct implications for bilateral assistance programs. Private actors could find themselves providing a larger share of global health finance than they ever anticipated.

### *Philanthropy*

In the last decade there have been significant increases in philanthropic giving. The BMGF was third only to the US and UK governments in terms of percent change in DAH between 2004 and 2015 (Figure 6).

The volume of assistance coming from philanthropic foundations is expected to continue growing considerably over the coming years. In 2010, 40 of America's wealthiest citizens pledged to give away at least half of their fortunes in The Giving Pledge (Strom, 2010). It was launched by Bill and Melinda Gates and Warren E. Buffet to stimulate discussion and leverage more philanthropic giving. There are currently 156 signed pledges representing billionaires from 16 countries (The Giving Pledge, 2016). There are mixed reviews about the effectiveness of this non-binding pledge (Coffey, 2015), but if it delivers on its promise, it will mobilize an unprecedented level of individual giving. As of 1 March 2016, there are a reported 1,810 billionaires with aggregate net worth of US\$6.48 trillion (Forbes Corporate Communications, 2016). These billionaires are from 67 countries and territories with the US hosting the most, followed by China, then Germany, India, and Russia (Forbes Corporate Communications, 2016). If the Giving Pledge managed to mobilize half of the billionaires to donate half of their fortunes over the next 100 years, it would amount to US\$16.2 billion per year.





*Figure 6. Percent change in DAH sources, 2004-2015*  
(IHME, 2016)

This is not to say that all of this wealth would be dedicated to health, that it would be invested effectively and with realistic expectations, or that the Giving Pledge provides any guidance for socially conscious billionaires. Facebook founder Mark Zuckerberg and his wife Priscilla Chan wrote a commitment letter to the Giving Pledge on 9 November 2015 (The Giving Pledge, 2016) pledging most of US\$46 billion in Facebook, Inc. shares. Their pledge was regarded as setting a “new giving standard” (Frier, 2015). But as time passes, it is unclear what new standard they are setting. On 21 September 2016 they announced their goal of “curing all disease in our children’s lifetime” with a US\$3 billion investment in scientific research and engineering (Cha, 2016). To say this is a lofty goal would be an understatement. As a point of direct comparison, the BMGF has dedicated US\$26.0 billion to global health since 1999 (IHME, 2016). Or to compare it to efforts in the profit-driven private sector, Sanofi Pasteur has spent €1.5 billion over 20 years in the development of a vaccine for a single disease, dengue fever (Sanofi, 2016).

Unrealistic expectations aside, their approach to this “new giving standard” has been called into question. Their investment is channelled through the Chan Zuckerberg Initiative, a limited liability company (LLC) rather than a charitable trust or private foundation (Singer and Isaac, 2015). This exempts them from tax, but it also allows them greater flexibility in how they use the money. Under an limited liability company (LLC) the Chan Zuckerberg Initiative can, for example, invest in for-profit social enterprises (Dolan, 2015). This model is an example of a predicted rise in so-called philanthrocapitalism. In 2006 a young Indian philanthropist suggested that his contemporaries would opt for philanthropic models that more closely “resemble the capitalist economy” (The Economist, 2006).

The US spends more money on health per capita and performs poorly in many health outcomes (OECD, 2014a). So it is not altogether surprising that wealthy individuals feel that they, the technocratic oligarchs, are better suited to allocate resources than a bloated bureaucracy that would absorb their fortunes in the name of social protection through taxation. That said, it would be prudent for these actors to practice transparency in order to enable proper objective measurements of effectiveness. This will benefit recipients as well as contribute to donor demands for return on investment.

Despite growing interest in philanthropic giving, there is a lag in adherence to internationally agreed upon principles of development assistance (Chapter 4). Currently the BMGF is the only philanthropic foundation to report to the OECD (OECD, 2016g), and the only donor included in evaluations on quality of its assistance (Birdsall and Kharas, 2014). Though it scored well, the BMGF was only evaluated on nine out of 31 indicators (CGD, 2016). As the relevance of these donors increases, the metrics for evaluating assistance should adapt to make conventional and emerging donors assistance more comparable.

It is important to note that this discussion focuses on American philanthropy, and while they are the largest cohort, they are not alone. There is an increasing awareness among the ultra-wealthy outside of the US, and time will tell if the American philanthrocapitalism model will be the one that newcomers will assume.

### *Corporate Social Responsibility*

There is no single definition or set of guidelines for corporate social responsibility, in essence it “is a business approach that contributes to sustainable development by delivering economic, social and environmental benefits for all stakeholders” (Financial Times, 2016).

The UN Global Compact was formed in 2000 and more than nine thousand business have joined select UN agencies, civil society organizations, and governments to promote ten principles of corporate social responsibility (CSR) (UN Global Compact, 2016a). The ten principles span human rights, labor, environment, and anti-corruption (UN Global Compact, 2016b). Furthermore in 2011 state and corporate actors have agreed to the UN Guiding Principles on Business and Human Rights to increase corporate transparency and accountability while empowering civil society and other advocates (UN, 2011). While rhetoric on health is absent among international principles and health in specialized international reports refers only to worker health and safety (UNCTAD, 2011, UNCTAD, 2012), corporate giving for health has increased (Figure 6).

There are a number of entry points for corporations in global health. Pharmaceutical companies provide support for product involvement, health systems strengthening, mHealth initiatives, advocacy and policy, health awareness campaigns, among others (Droppert and Bennett, 2015). The success of some CSR programs has resulted in their inclusion in national strategies. For example, AngloGold Ashanti's malaria control program has been scaled up as a part of Ghana's national strategy (AngloGold Ashanti, 2013). Aside from providing services, there has been a call to integrate and formalize health impact assessment (HIA) in corporate social responsibility programs. Due to the magnitude and pervasiveness of the extractive industry, it is important that HIA is universally institutionalized (Lee et al., 2013, Winkler et al., 2013) and that the corporate social responsibility arm of the industry coordinates with the national health system.

CSR for health can also include engagement with more established channels. Coca-Cola, Chevron, EcoBank, Standard Bank, Takeda Pharmaceuticals, and Vale are all examples of corporations who provide finance to the Global Fund (The Global Fund, 2016q). Additionally, some corporations have received finance, as Principle Recipients, from the Global Fund, e.g. AngloGold Ashanti in Ghana and Philipinas Shell Foundation in the Philippines (The Global Fund, 2016d). Though in such instances, the definition of CSR becomes blurry when the corporation is receiving finance from a predominantly publicly funded agency.

As with philanthropic foundations, corporations with social responsibility programmes do not provide data that allow for tracking or evaluation of effectiveness (OECD, 2016g, CGD, 2016). Though multiple corporations are associated with netFWD (Table 4), discussions with in-country partners (Chapter 4), absence from global resource data repositories, and gaps in literature all suggest that these actors are not yet adhering to the agreed upon Guidelines for

Effective Philanthropic Engagement (Partnership for Effective Development Cooperation, 2014).

### 1.3 Support from emerging economies

The OECD acknowledges that non-DAC providers of development assistance play an increasingly important role (OECD, 2016e). Twenty non-DAC countries now report to the OECD, though many only at the aggregate level; furthermore the OECD estimates the volume of development assistance from an additional ten countries (Table 5) (OECD, 2016e). Though the data captured are not exhaustive and estimates are not disaggregated by sector (Steensen, 2014), it is a step in the right direction.

*Table 5. Non-DAC countries captured in OECD statistics*

Report to the OECD		Estimates for development cooperation
Bulgaria	Chinese Taipei	Brazil
Croatia	Thailand	Chile
Cyprus	Timore Leste	People's Republic of China
Estonia	Turkey	Colombia
Hungary	United Arab Emirates	Costa Rica
Israel		India
Kazakhstan		Indonesia
Kuwait		Mexico
Latvia		Qatar
Liechtenstein		South Africa
Lithuania		
Malta		
Romania		
Russian Federation		
Saudi Arabia		

(OECD, 2016e)

Estimates for non-DAC ODA for 2012/2013 vary widely, ranging from US\$11.6 billion to US\$20 billion (Steensen, 2014, MDG Gap Task Force, 2015).

### BRICS

In 2001 a Goldman Sachs economist coined the acronym BRIC (Brazil, Russia, India, and China) in his discussion on emerging market economies and the need to include them in global policymaking forums (O'Neill, 2001). What began as a catchy phrase in an investment bank's research note has developed into a full-fledged institution complete with an arsenal of websites, think-tanks, an interbank cooperation, annual summits, and its own development bank.

In the beginning there were debates about the cohesiveness of this group (Armijo, 2007). Due to their political, regional, and economic differences and diverse interests, did it make sense to group these countries together? By now this debate is somewhat obsolete; they have self-identified as a bloc by launching joint initiatives. The volume, exact nature, and effectiveness of emerging donors' engagement with recipient countries remain unclear.

*Although all countries other than Russia are reported to receive official development assistance for health; it is a negligible in terms of total expenditure for health (*

Table 6). Brazil, China, and Russia are all categorized as having high human development and India and South Africa with medium human development.

South Africa's government has the highest priority for health (using government expenditure for health as percent of total health expenditure as a proxy) followed by China. India's government dedicates the least of its budget to health in this cohort. Due to the dearth of DAH from these countries it is unclear if these trends in health as a priority extend to development assistance abroad.

*Table 6. BRICS comparative indicators*

	Brazil	Russia	India	China	South Africa
GDP per capita, PPP (current intl \$)	15,359	24,451	6,089	14,239	13,165
GDP annual growth rate	-3.847	-3.727	7.57	6.9	1.283
Government expenditure on health as % of total health expenditure*	46.04	52.20	30.04	55.79	48.24
Government expenditure on health as % of total government expenditure*	6.78	9.49	5.05	10.43	14.23
Official develop assistance for health disbursements per capita**	1.7	...	22.6	6.6	63.9
External resources for health as % of total health expenditure*	0.13	...	0.95	0.03	1.84
HDI†	0.0755	0.798	0.609	0.727	0.666
HDI rank†	75	50	130	90	116

\* WHO estimates, 2014 (WHO, 2016b), \*\* World Bank Population estimates, 2014 (The World Bank, 2016) and OECD ODA CRS statistics, 2014 (OECD, 2016g), †Human Development Index (UNDP, 2015)

Brazil and Russia have the largest economies but both have negative growth rates (Figure 7). Brazil's has plummeted from a growth rate of 7.5 percent in 2010; and Russia has also experienced a quick decline from a rate of 4.5 percent in 2010 (The World Bank, 2016). China has a robust economy that has remained relatively stable, but India's experienced more volatility with a precipitous drop in 2010 and a subsequent rebound in 2012. All have seen considerably slowed growth since the global financial crisis. Though this could affect the volume of their development assistance for health in the long run, they have carried forward with a couple of their joint initiatives.

The 8<sup>th</sup> BRICS Summit in October 2016 was hosted in Goa, India (BRICS, 2016a). The Goa Declaration renewed its commitment to cooperate to achieve BRICS' targets for HIV and tuberculosis, including research, development, and production of drugs and diagnostics (BRICS, 2016b).

The BRICS Trade & Economics Research Network (BRICS-TERN), a network of five think-tanks, was established in 2011. It focuses on "network-based policy research and advocacy on contemporary developmental issues" with the objective of sustainable development through the promotion of fair markets and inclusive growth (BRICS-TERN, 2016). Only one of five reports they have produced nominally mentions health development; it touches upon a few social determinants of health such as food security and labour-related issues (Singh and Dube, 2012). A subset of the BRICS have also established a trilateral free trade agreement, IBSA Trilateral (India, Brazil, and South Africa) (IBSA, 2016b), to promote trade and investment opportunities among the Southern African Customs Union (SACU), Mercosur, and India. The IBSA Dialogue Forum was launched in 2003 to promote South-South cooperation and exchange. It has a Joint Working Group for health that signed a trilateral Memorandum of Understanding in 2007 (IBSA, 2016a). Priority areas include surveillance, research and development, integrating regulations, intellectual property for medicines, etc. The Joint Working Group for health has not met since 2013 (IBSA, 2016a).

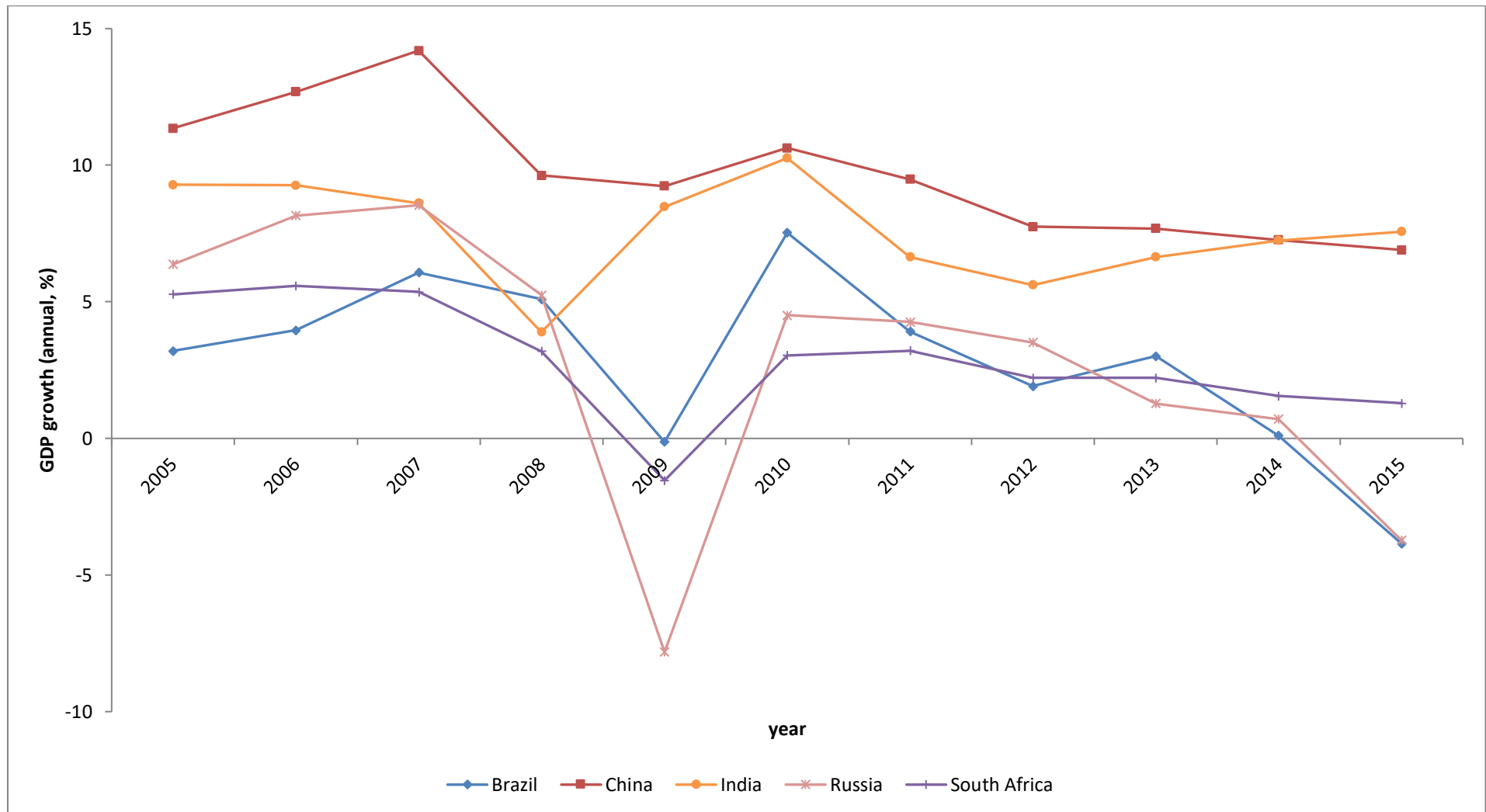


Figure 7. BRICS annual GDP growth, 2005-2015  
(The World Bank, 2016)



In 2014 the BRICS announced the launch of the New Development Bank (NDB). It will have an initial capital pool of US\$50 billion that will be equally divided; it will maintain a currency reserve of US\$100 billion (Panda, 2014). Its headquarters will be in Shanghai, China, and the first president will be Indian. The bank has been established, in part, to challenge the Western order maintained by the World Bank and the International Monetary Fund (Panda, 2014). The NDB will focus on infrastructure projects in developing contexts (NDB BRICS, 2016).

So far, the majority of the bloc's activity has centered upon economic growth and establishing financial and trade relationships. BRICS countries have individually provided foreign assistance since the 1950s (Mwase and Yang, 2012). Scholars have identified a number of trends in BRICS' development efforts such as applying principles of South-South Cooperation (G77, 2009b) focusing on partnership; avoiding policy conditionality in governance, economic policy, or institutional reform; structuring assistance to complement foreign direct investment; emphasizing individual project feasibility rather than long-term debt sustainability; and applying domestic development lessons (Watson et al., 2013, Mwase and Yang, 2012). The intention to develop their own agenda for development assistance is particularly interesting in light of the fact that their domestic health sector resource allocation appears to be still highly influenced by current multilateral donors such as the World Bank and the Global Fund (Sridhar and Gomez, 2011a).

### **Brazil**

Brazil defines their foreign assistance as "international cooperation", emphasizes partnership, and focuses on technical cooperation rather than grants or concessional loans (Vaz and Inoue, 2007). Brazilian civil servants and professionals provide technical assistance and technological transfer (Russo et al., 2013); this model could prevent macroeconomic repercussions associated with (non-)absorption of traditional aid (Allen, 2005). The Brazilian Cooperation Agency (ABC; an adjunct of the Ministry of External Affairs), multiple government ministries, and public health institutions all play active roles in international cooperation (Vaz and Inoue, 2007, Russo et al., 2013). Though it currently lacks a centralized institution responsible for foreign assistance, it is working towards greater inter-agency coordination.

Brazil prioritizes support for the Lusophone countries, South America, and the Caribbean but is expanding its engagement as is evidenced by its participation in BRICS fora and IBSA. Brazil's foreign assistance is openly aligned with, and driven by, foreign policy goals (Saraiva, 2010, Gomez, 2012). Brazil has called on governments to follow its lead and integrate global

health into their foreign policies as an official recognition of the fundamental role of health in international relations (Amorim et al., 2007). Its priorities in health, specifically, are determined by its foreign policy priorities, health-specific expertise, and the demands of partner countries (Tytel et al., 2012). Brazil's health diplomacy efforts have focused most notably on tobacco control and Intellectual Property Rights (Tytel et al., 2012, Ortiz, 2011).

Brazil has formed bilateral partnerships with selected low-income countries to donate treatments and transfer technologies and best practices for national HIV/AIDS and access to antiretrovirals (ARV) programs based on domestic success starting in the 1990s (Pimenta et al., 2006). Brazil has become a global leader in nutrition policy and programming due to its successes in reducing domestic poverty rates and child hunger (CEBRI, 2010, Leão and Maluf, 2013). It has also assisted in the development of extensive milk banks across Latin American and Africa (Government of Brazil, 2011, Dominican Today, 2007). These banks serve as a tool to prevent mother-to-child transmission of HIV while promoting breastfeeding as a means of improving infant nutrition (PATH, 2016). It has provided financial and technical support for the development of the first public pharmaceutical manufacturing facility in Africa; ARVs are now being produced in Maputo, Mozambique (Government of Brazil, 2011, Russo and de Oliveira, 2016).

### *Russia*

Russia's engagement with the other BRICS nations reflects a foreign policy that stems from its desire to be a non-Western world power (Mankoff, 2009, Walz and Ramachandran, 2010). Surprisingly, Russia has aligned itself with the aid agendas of the OECD-DAC countries, unlike other BRICS (Walz and Ramachandran, 2010, Zimmerman and Smith, 2011). Since 2015 Russia has reported its ODA (Table 5), but there is no data for disbursements for health (OECD, 2016g). The Ministries of Finance, Foreign Affairs, and Affairs of Civil Defence, Emergencies and Disaster Relief oversee all assistance programs (Government of Russia, 2007). Russia focuses on global poverty reduction and prioritizes education and infectious disease control (The World Bank, 2011).

One quarter of Russia's foreign assistance is dedicated to health and is channelled through multilateral institutions such as the Eurasian Economic Community, the World Bank, the United Nations (Zimmerman and Smith, 2011), the Global Fund, and GAVI Alliance. Russia contributes significantly to the Global Polio Eradication Initiative; regional polio eradication

has become a major priority in response to outbreaks that have crossed the border from neighboring countries (Tytel et al., 2012).

The majority of Russia's bilateral assistance targets the Commonwealth of Independent States (CIS) and primarily focuses on HIV/AIDS, surveillance systems, and neglected tropical diseases (Zimmerman and Smith, 2011). Health security appears to steer priorities (Gómez, 2009). For example, the highest proportion of bilateral health assistance is dedicated to disease surveillance programmes in neighbouring countries (Government of Russia, 2007). Trilateral assistance includes malaria control and prevention programmes in sub-Saharan Africa and training in Africa, the Middle East, and former Soviet republics (Tytel et al., 2012).

### *India*

Like other BRICS countries, India uses foreign assistance for diplomatic purposes and emphasizes cooperation, South-South partnership, addressing recipient demand, technical capacity building, and sustainability (Jobelius, 2013). The majority of India's foreign assistance is dedicated to sectors other than health, though there is a predicted increase over the coming years. Domestic obstacles limit foreign health assistance to strengthening of secondary and tertiary care, maternal and child health care, and non-communicable disease prevention and management (Tytel et al., 2012). India favors projects for infrastructure, information technology, and training; the majority of foreign assistance is technical aid (Jobelius, 2013).

India primarily uses bilateral channels for foreign health assistance and prioritizes countries in South and Southeast Asia, and Africa. It commonly supports the construction or improvement of hospitals and clinics, the provision of medical supplies, and the supply of equipment and technology. India has also provided faculty support and established medical colleges in neighboring countries due to its experience with developing a well-trained health workforce (Tytel et al., 2012). A notable project within India's bilateral framework is the Pan-Africa Telemedicine and Tele-Education Network. Best practices are shared with West African universities and hospitals (PAeN Project, 2016, AU, 2016).

The private sector, including the pharmaceutical industry, has been taken the lead in domestic global health innovations. Low-cost manufacturing of generic pharmaceuticals coupled with vaccine production has been India's largest contribution (Waning et al., 2010, Government of India, 2011), along with its novel approaches to low-cost health service delivery (Inderfurth and Khambatta, 2011) such as the initial studies for directly-observed treatment short-course (DOTS) that revolutionized the tuberculosis treatment strategy.

## *China*

In recent years, China's has increased its emphasis on health as a priority for development assistance. Some estimates of their DAH place them in the top 10 bilateral global health donors (Grépin et al., 2014). Though China has played a significant role in regional discussions on public health preparedness and disease surveillance. Its primary foci are health infrastructure, human resources capacity building, provision of international medical teams, reproductive health and family planning, and malaria control (Tytel et al., 2012). Health assistance is used as a diplomatic tool to bolster its image abroad as well as secure access to natural resources (Bliss et al., 2010, Huang, 2010).

Bilateral channels are the primary means of Chinese foreign health assistance with Africa as the principle target. The Forum on China-Africa Cooperation (FOCAC) serves to strengthen trade and development ties (FOCAC, 2016), and the framework includes malaria treatment and control programmes (Huang, 2010). Its projects are not currently integrated with other global malaria programme (Tytel et al., 2012). China has been sending medical teams abroad since the 1960s; these teams provide free medical care and train local medical staff in areas lacking access to health services (Huang, 2010). China funds the construction of hospitals, clinics, and pharmaceutical manufacturing facilities, primarily in Africa (Bräutigam et al., 2011). It also provides funds for health commodities and medical equipment.

## *South Africa*

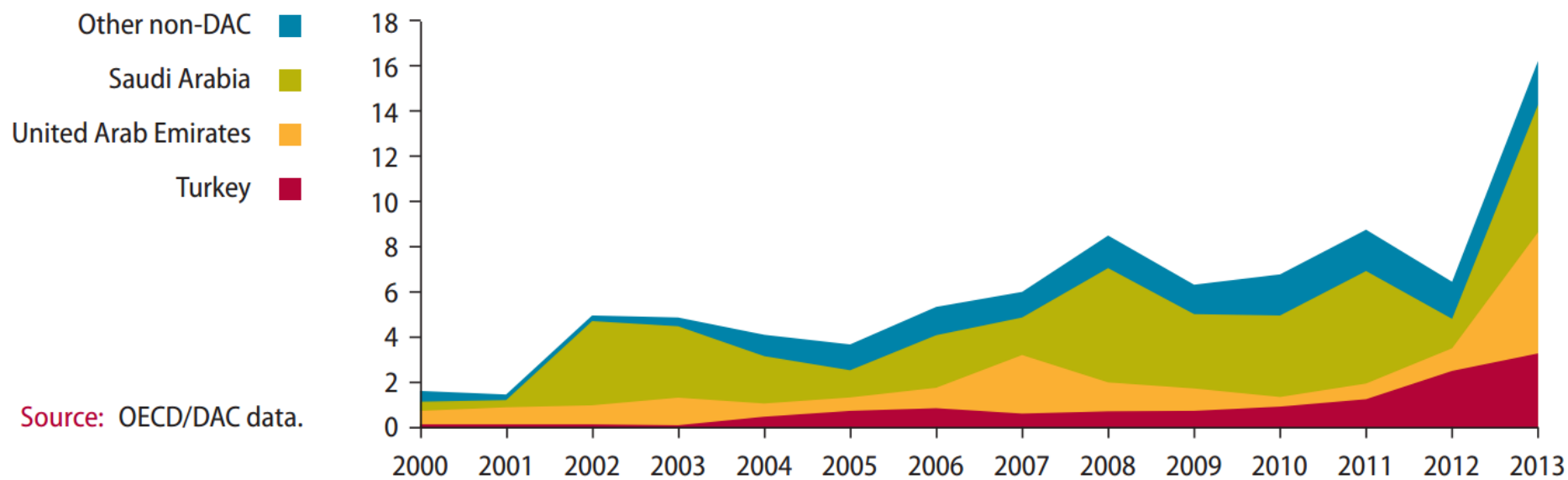
South Africa must focus primarily on its high domestic burdens of HIV/AIDS and tuberculosis. Its chief role in development assistance is arguably as a model for other countries in terms of clinical research, advocacy, policy. Though South Africa receives more funds than it donates, it does contribute to foreign assistance for health through multilateral agencies, bilateral partnerships, and South-South cooperation. Its assistance is delivered mainly in the form of grants and technical support to other African countries. South Africa hosts a number of important research institutes and is a regional center for research and development of medicines and vaccines for various infectious diseases. Generic drugs, including first-line ARVs, are produced domestically (Tytel et al., 2012).

While the BRICS have declared that health collaboration is a priority, they haven't yet begun working collectively to enhance the impact of their assistance programs. Of the bloc, China has contributed the largest sum of foreign assistance to low-income countries approximating US\$50 billion, as of 2012 (Grépin et al., 2014, AidData, 2016). Overall, health has been a main focus

of Brazil and Russia's foreign assistance agendas, while it has been less emphasized in the agendas of China, India, and South Africa (Tytel et al., 2012).

### *Non-BRICS emerging economies*

Aside from the BRICS, there are a number of non-DAC countries increasing their official development assistance. For example, the United Arab Emirates reached the highest GNI ratio of ODA of any country at 1.17 percent (MDG Monitor, 2016). Turkey doubled its aid between 2011 and 2012 (Figure 8) (Di Commo, 2014). More recently, Hungary, Estonia increased their aid between 2013 and 2014 by 24.4, 19.2, and 8.2 percent, respectively (MDG Monitor, 2016). In all, ODA from non-DAC providers is approaching 20 percent of total ODA (OECD, 2016e).



*Figure 8. Development finance from non-DAC providers reporting to OECD, 2000–2013*  
(billions, US\$) (UN, 2015)

Currently some of these donors provide data through national reporting systems that are not formatted for cross-comparison with other donors, and for others only rough estimates are available (Steensen, 2014). Though in-country stakeholders are familiar with many non-BRICS, non-DAC actors, for now the volume of assistance by sector and recipient remains unclear (Chapter 5). Until we have more information and comparable statistics, it is impossible to evaluate the effectiveness of this assistance.

### 1.4 The Global Fund

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) is a financial instrument established in early 2002 (Sherry et al., 2009). Its formation was part of the “emergency response to accelerate the scale-up of control of the major communicable diseases, especially HIV/AIDS” in light of the Millennium Development Goals (MDGs) (Biesma et al., 2009). Although it is a relatively young organization, it has quickly adapted to practicing within global governance standards. It reports its disbursements to the OECD DAC and is a member of the International Aid Transparency Initiative (IATI) (OECD, 2016g, IATI, 2016b).

By the end of 2015 the Global Fund had saved an estimated 20 million lives (The Global Fund, 2016e). It is the largest finance channel for malaria and tuberculosis, providing US\$920 million and US\$610 million, respectively, in 2014 (40 and 49 percent of total support, respectively) (IHME, 2016). It is the second largest channel for HIV/AIDS, behind the President’s Emergency Plan for AIDS Relief (PEPFAR), providing US\$1.7 billion in 2014 (16 percent of total support) (IHME, 2016). Along with funding the three diseases, it provides both disease-specific and system-level health systems support (Warren et al., 2013).

Since its inception, it has disbursed more than US\$30.6 billion (The Global Fund, 2016a). In terms of overall contribution, the Global Fund was responsible for nine percent of funding for global health in 2015; it reached its maximum in 2012 and 2013 when it oversaw the disbursement of 12 percent of the total funds dedicated to DAH (IHME, 2016).

Governments provide approximately 95 percent of Global Fund support; the private sector provides remaining 5 percent (The Global Fund, 2016o). For this reason, the Global Fund is considered a public-private partnership. Although the private sector does not provide a significant amount of finance they do contribute significantly to the agency’s governance. They are represented by two of 20 voting constituencies (Table 7).

*Table 7. Voting constituencies of the Global Fund Board*

<b>Implementer Bloc</b>	<b>Donor Bloc</b>
Eastern Europe and Central Asia	Canada and Switzerland
Eastern Mediterranean	European Commission**
Eastern and Southern Africa	France
Latin American and the Caribbean	Germany
Southeast Asia	Japan
West and Central Africa	Point Seven***
Western Pacific Region	United Kingdom and Australia
Communities*	United States
Developed Countries NGOs	Private Foundations
Developing Countries NGOs	Private Sector

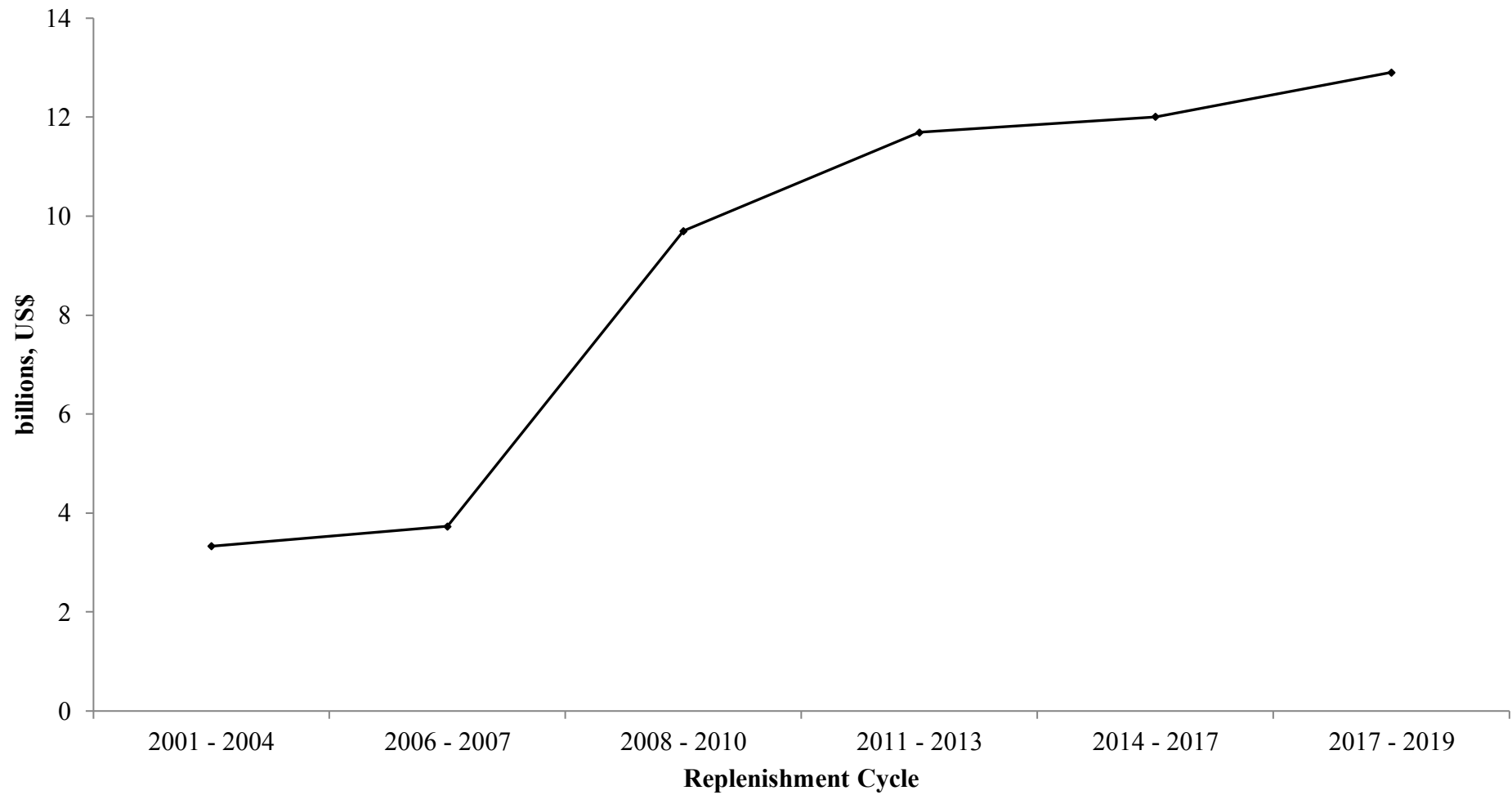
\*NGOs representative of the communities living with the diseases; \*\*Belgium, Italy, Portugal, Spain; \*\*\*Denmark, Ireland, Luxembourg, Netherlands, Norway, Sweden (The Global Fund, 2014)

Earlier this year the Global Fund had its fifth replenishment where donors committed US\$12.9 billion for the next three years (The Global Fund, 2016c). It raised more over US\$1 billion more than the previous replenishment (Figure 9). Many bilateral donors increased their pledges, private donors more than doubled their total contribution, and several low- and middle-income countries made pledges to show their commitment to the global fight against the three diseases (The Global Fund, 2016c).

This most recent replenishment demonstrates continued support after a couple of tumultuous years and subsequent reform. In 2010 the Office of the Inspector General (OIG) conducted investigations into allegations of fraud, corruption, and misuse of funds in seven countries (The Global Fund - OIG, 2010). Shortly thereafter the Global Fund received its largest replenishment, to date, at US\$11.7 billion (Figure 9).

On 23 January 2011, the Associated Press published a story, “Fraud Plagues Global Health Fund” (Heilprin, 2011). More than 250 media outlets worldwide covered the story and within days Germany froze its contribution to the Global Fund (Rivers, 2011). Over the coming months the Global Fund underwent independent review, re-visited its 5-year strategy, and committed to urgent reform (The Global Fund, 2011c, The Global Fund, 2011b, The Global Fund, 2011a). Within one year, Gabriel Jaramillo, former Chairman and Chief Executive Officer of Sovereign Bank, was appointed as General Manager to oversee the transformation plan (The Global Fund, 2012b).



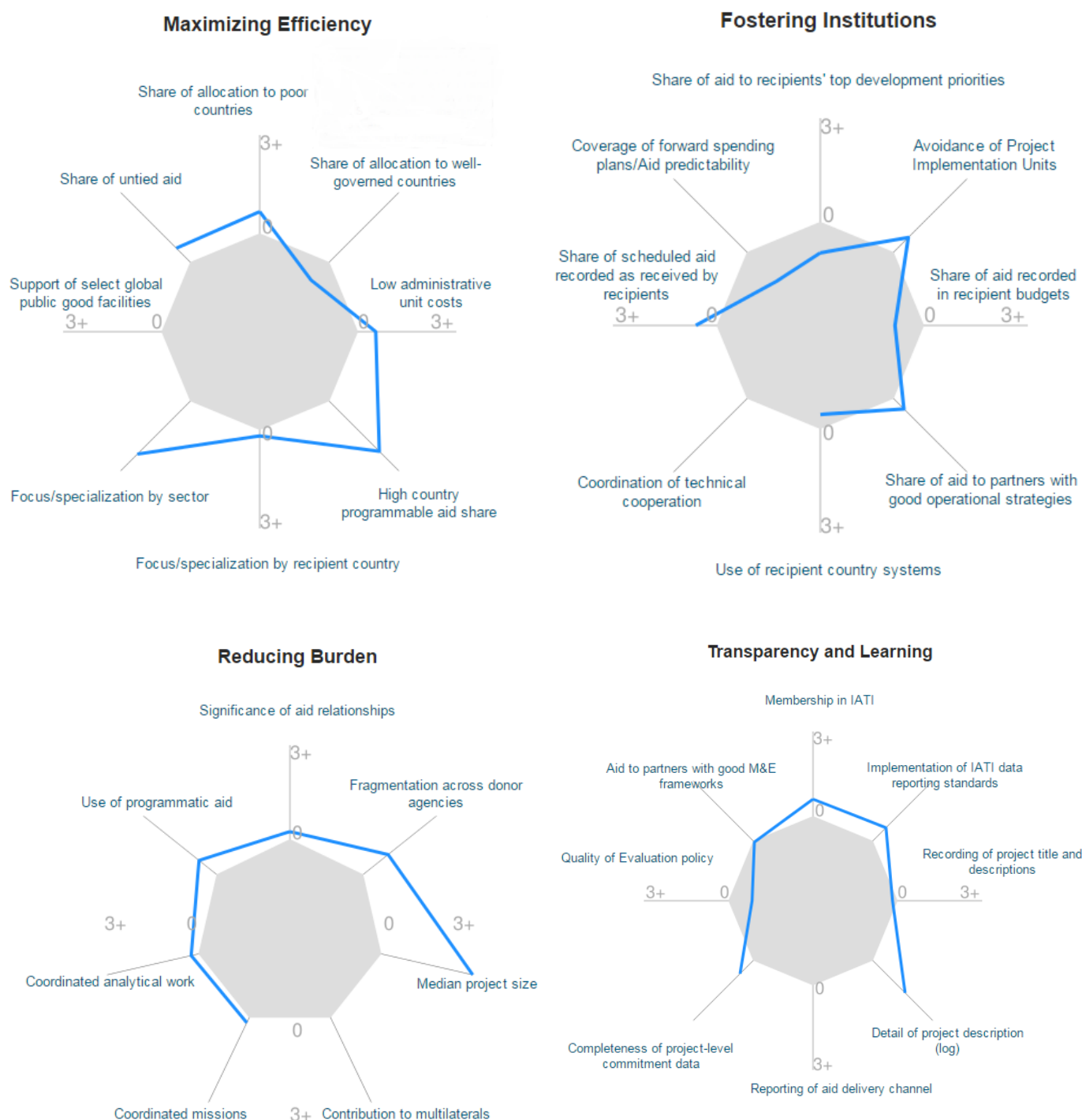


*Figure 9. Global Fund replenishments*

(The Global Fund, 2005a, The Global Fund, 2005b, The Global Fund, 2007, The Global Fund, 2010c, The Global Fund, 2013a, The Global Fund, 2016p)

Reforms resulted in what became known as the New Funding Model (NFM). It has five key characteristics: flexible timeline, simplified grant application processes, shorter approval processes, enhanced engagement of all partners prior to grant submission, and improved predictability of funding (The Global Fund, 2016b). In short, the reform focuses on processes, not structure or paradigm (Chapter 6).

The OIG systematically audited recipients and identified \$118 million in losses as of 19 September 2013 (Garmaise, 2013). It is important to note that these losses are only 0.5 percent of the \$22.7 billion that the Global Fund had disbursed worldwide at the time (The Global Fund, 2016d). Overall, the Global Fund has a particularly high level of financial accountability and is diligent in its response to these relatively small abuses (Figure 10).



*Figure 10. Quality of Global Fund assistance, 2014*

Zero represents the average score. Scores within the gray diamond are below the mean and scores outside it are above the mean. Scores outside the range -3 to 3 are rounded to those values for display (CGD, 2016).

In the Center for Global Development's evaluation of development assistance quality, the Global Fund scored better than average on 19 of the out of the 24 indicators that it was scored on (Figure 10). Overall it scored above the mean (when compared to OECD DAC donors) in the dimensions Maximizing Efficiency, Reducing Burden, and Transparency and Learning. It

scored below the mean for Fostering Institutions (CGD, 2016). Out of 33 donor agencies, the Global Fund was ranked first in Maximizing Efficiency, fifth in Transparency and Learning, 13 in Reducing Burden, and 27 for Fostering Institutions (CGD, 2016).

The low score for Fostering Institutions was in part due to poor aid predictability, but this could improve with the changes associated with the New Funding Model (Garmaise, 2013). An additional weakness in the Fostering Institutions dimension is that much of Global Fund's finance does not go through the public financial management systems and is therefore not reflected in recipients' budgets (Birdsall and Kharas, 2014). Issues such as use of recipient country systems need to be tackled at the governance level.

Identifying quality of assistance is particularly useful for an agency such as the Global Fund. They have proven themselves capable of reform which is unique for a large-scale organization (Hanrieder, 2016, Kelland, 2016). This direct comparison of the Global Fund and the bilateral agencies of its funders allows for a focused sharing of best practices among Board constituencies. Such discussions could also have a trickle-down effect for private foundations and corporations who are on the Board. Overall, the Global Fund is an example of a highly successful global health institution and emerging donor.

## 1.5 Donor darlings and orphans

This thesis focuses on the influence of emerging actors in health development in Chad, Ghana, Mozambique, and Tanzania- four countries that span the donor-darling / donor-orphan spectrum (Van de Maele et al., 2013). Chad is classified as a “donor orphan”; it is ranked in the bottom 10 in terms of commitments and disbursements of DAH based on the OECD's DAC's credit reporting system (CRS) (Table 9). Using the same indicators, Mozambique is classified as “donor darling” (Table 8). Likewise, Tanzania is classified as a darling using the Global Health Expenditure Database. Ghana falls between a darling and an orphan across all three classifications (Van de Maele et al., 2013).

This phenomena reflects gaps in coordination amongst donors (MDG Gap Task Force, 2015). Coordination for health typically happens at the country-level for specific activities, but as the donor-darling / -orphan gaps illustrate, more can be done at the global level to ensure that resource allocation becomes more needs-based.

*Table 8. Top 10 development assistance for health countries, by data source (2012)*

<b>Expenditure (GHED)</b>		<b>Commitments (OECD DAC CRS)</b>		<b>Disbursements (OECD DAC CRS)</b>	
<b>Country</b>	<b>US\$*</b>	<b>Country</b>	<b>US\$*</b>	<b>Country</b>	<b>US\$*</b>
Namibia	353	Botswana	465	Botswana	389
Botswana	303	Namibia	412	Namibia	321
Zambia	167	Swaziland	263	Zambia	207
Rwanda	130	Zambia	258	Swaziland	187
Swaziland	119	Lesotho	231	Rwanda	172
Malawi	116	Rwanda	218	Malawi	136
Lesotho	84	Malawi	172	Mozambique	132
United Republic of Tanzania	76	Mozambique	159	Lesotho	121
Uganda	74	Liberia	155	Liberia	109
Gambia	70	Uganda	125	Uganda	108

\*per capita US\$ (Van de Maele et al., 2013)

*Table 9. Bottom 10 development assistance for health countries, by data source (2012)*

<b>Expenditure (GHED)</b>		<b>Commitments (OECD DAC CRS)</b>		<b>Disbursements (OECD DAC CRS)</b>	
<b>Country</b>	<b>US\$*</b>	<b>Country</b>	<b>US\$*</b>	<b>Country</b>	<b>US\$*</b>
Mauritius	3	Mauritius	6	Mauritius	5
Guinea	16	Sudan	27	Sudan	24
Central African Republic	17	Guinea	32	Cameroon	29
Sudan	23	Chad	33	Guinea	32
Nigeria	23	Cameroon	36	Nigeria	32
DRC	25	Madagascar	44	DRC	35
Congo	27	Nigeria	45	Chad	39
Madagascar	30	DRC	48	Togo	39
Côte d'Ivoire	30	Central African Republic	48	Côte d'Ivoire	42
Angola	31	Mauritania	48	Angola	45

\*per capita US\$ (Van de Maele et al., 2013)

## 1.6 Rationale for thesis

From 2003, sub-Saharan Africa consistently received the largest share of DAH. On average, it accounts for more than 24.5 percent of total international expenditure on health from 2000 to 2012. The vast majority of its support comes from governments, multilateral agencies, and partnerships such as the Global Fund and the GAVI Alliance (IHME, 2015). It is difficult to tease out how much support comes from private sources as they enter recipient countries through other channels, ex. NGOs. The majority of money coming from private foundations and corporations is deemed unallocatable. The only private foundation that was tracked from source to recipient was the BMGF which allocated 25.3 percent of its funds to sub-Saharan Africa in 2012 (IHME, 2015).

Shared roles and responsibilities blur the division between the private and public sectors' aims and responsibilities (Buse and Walt, 2000). This raises concerns about legitimacy, accountability, and international cooperation (Hein and Kickbusch, 2010b) as well as concerns over potential conflicts of interest (Stuckler et al., 2011a), divergence from national strategies, and lack of harmonization among donors (Piva and Dodd, 2009). The influence of increasing plurality of the global health financing system on the coherence, efficiency, and effectiveness of health development programmes requires further investigation (McCoy, 2012).

A growing proportion of development assistance for health comes from “unofficial” sources and therefore isn’t tracked or properly evaluated. Although many emerging donors have expressed support for international aid effectiveness principles, the influence of their support at country-level and there level of adherence to international guidelines has been unclear.

## 2. Aims and Objectives

### 2.1 Aims

This thesis aims to contribute to the literature on development assistance for health and the influence of emerging donors for health, specifically the Global Fund, philanthropic foundations, corporate social responsibility, and emerging economies. It provides a glimpse of in-country perceptions of the successes and challenges of working with these partners.

The insights gained from this research can contribute a greater understanding of the priorities of stakeholders who work within recipient health systems as well as the culture of managing development assistance for health in-country.

### 2.2 Objectives

The overarching goal of this PhD thesis is to provide country-level insights of the nature and influence of emerging actors in the development assistance for health landscape. Each of the four case-study countries has a different existing relationship with providers of official development assistance to health. It was unknown if the trends are reflected in relationships with new donors or if donors who act outside of “official” development assistance channels establish their own unique norms.

This thesis has three broad objectives:

**Objective 1 : To understand the nature of emerging donors’ development assistance for health in selected sub-Sahara African countries**

Specific objectives:

- To illustrate the visibility of emerging economies and private donors acting in global health
- To understand the range of activities supported by emerging donors
- To uncover the type of assistance coming from emerging donors- financial or in-kind

**Objective 2 : To understand the influence of emerging donors’ development assistance for health in selected sub-Sahara African countries**

Specific objectives:

- How emerging donors influence country-level activity, in terms of:
  - achieving health outcomes
  - aid effectiveness
  - interactions among existing stakeholders
  - mechanisms for aid management
- The successes and challenges of the Global Fund from the recipient's perspective

**Objective 3 : To identify prospective roles and models of engagement with non-traditional actors in development assistance for health**

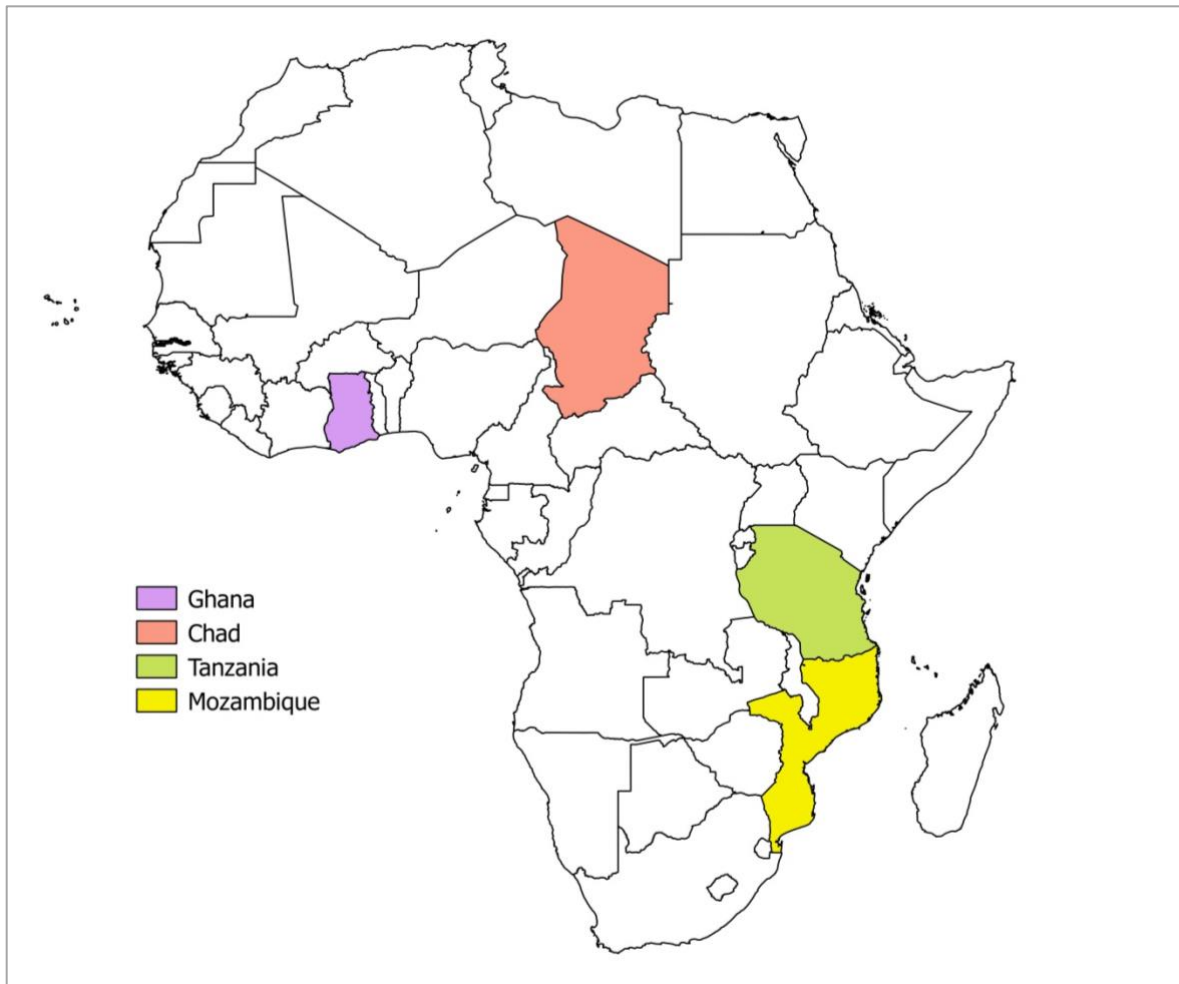
Given the existing nature and influence of emerging donors in health, what do in-country stakeholders think are realistic expectations regarding role and responsibility of emerging donors for health should be? What are country-level stakeholder priorities for future engagement?



### 3. Summary Methods

#### 3.1 Study areas

Chad, Ghana, Mozambique, and Tanzania are located in the Central, Western, Southern, and Eastern regions of sub-Saharan Africa, respectively (Figure 11).



*Figure 11. Map, case-study countries*

Tanzania is almost twice as populous as Ghana and Mozambique and has almost four times the population of Chad (Table 10). Its economy has remained relatively stable, in terms of GDP annual growth, since 2012 when it climbed steeply from an annual growth rate of 5.1. Likewise, Mozambique's growth has remained steady around 6.3 since 2009. On the other hand, Chad's economy has been volatile reaching a growth rate of 33.6 in 2004 and dropping to 0.6 in 2006. Most recently it has dropped from 6.9 in 2014 to 1.8. Ghana has been in steep decline since 2011 from its high of 14.0 (The World Bank, 2016).

Three of the four countries- Chad, Mozambique, and Tanzania- are placed in the “low human development” category (UNDP, 2015). They rank 185, 180, and 151, respectively, out of 188 countries. Chad and Mozambique scored lower than the composite for least-developed countries (0.502). Ghana is ranked at 140 and is categorized with “medium human development”. Compared to the entire region, Ghana and Tanzania have surpassed the average national adult literacy rate, but Ghana is the only country of the four to approach the regional rates for secondary education. Chad, Ghana, and Tanzania are plagued by limited capacity which inevitably spills over into health system management and performance (Chapter 6).

The four countries have relatively similar profiles in terms of government health expenditure but notable difference in total health expenditure due to the differences in level of external support (Table 11).

Total health expenditure per capita is lower in all four case-study countries than the region as a whole. Government expenditure on health as a percent of total health expenditure is comparable across all four countries with all except Tanzania around ten percent more than the region. When it comes to how much of the total government budget is dedicated to health, Tanzania’s government dedicates the largest proportion of its purse (12.3 percent), Chad and Mozambique’s dedicate roughly the same proportion (9.0 and 8.8, respectively), and Ghana is far behind at 6.8 percent (WHO, 2016b). This indicator is an approximation of how a government prioritizes health among the sectors. Remarkably the governments of Chad and Ghana, who represent this sample’s lowest and highest human development scores, are responsible for roughly the same proportion of total health expenditure and Chad’s government dedicates more of its budget to health than Ghana’s.

There are large disparities among the countries in terms official development assistance for health with divergence over time (Figure 12). Mozambique receives almost triple ODA for health per capita. Although these two have consistently represented the two extremes in our sample set since 2007, 2013 appears to have been a defining moment. Whereas Chad, Ghana, Tanzania, and the African region as a whole all saw a decrease in ODA for health per capita, Mozambique’s increased. Despite this increase, ODA for health as a percentage of total health expenditure in Mozambique continues to decrease (Figure 13) as a result of the government’s increased spending for health in recent years (data not shown).

*Table 10. Case-study countries: selected comparative indicators*

	<b>Chad</b>	<b>Ghana</b>	<b>Mozambique</b>	<b>Tanzania</b>	<b>African Region</b>
Population (millions*)	14.0	27.4	28.0	53.5	100.0
Urban population (% of total)	23	54	32	28	...
Gross national income per capita (PPP int. \$)*	2,110	4,070	1,170	2,620	3,562
GDP per capita (then-current US\$)*	775.7	1,381.4	525.0	864.9	1,571.3
GDP annual growth rate*	1.8	3.9	6.3	7.0	3.0
% population that lives below international poverty line (\$1.25 per day)	36.5	29.0	60.7	43.5	...
Adult literacy rate	37.3	71.5	50.6	67.8	60**
% population with at least some secondary education, female (ages 25 and older)	1.7	45.2	1.4	5.6	52**
% population with at least some secondary education, male (ages 25 and older)	9.9	64.7	6.2	9.5	69**
Human Development Index	0.392	0.579	0.416	0.521	0.518

(UNDP, 2015, The World Bank, 2016) \*World Bank estimates for 2015; \*\* World Bank estimates for 2010

*Table 11. Case-study countries: selected health financing indicators*

	<b>Chad</b>	<b>Ghana</b>	<b>Mozambique</b>	<b>Tanzania</b>	<b>African Region</b>
Per capita total health expenditure (PPP int. \$)	79	145	79	137	228
Total health expenditure as % of GDP	3.6	3.6	7.0	5.6	5.5
Government expenditure on health as % of total health expenditure	54.7	59.9	56.4	46.4	47.8
Government expenditure on health as % of total government expenditure	9.0	6.8	8.8	12.3	10.0
Official development assistance for health disbursements per capita*	4.2	6.5	12.1	6.9	5.6
External resources for health as % of total health expenditure	19.4	15.4	48.7	35.9	9.6

World Health Organization estimates for 2014 (WHO, 2016b)

\* World Bank Population estimates, 2015 (The World Bank, 2016) and OECD ODA CRS statistics (OECD, 2016g)

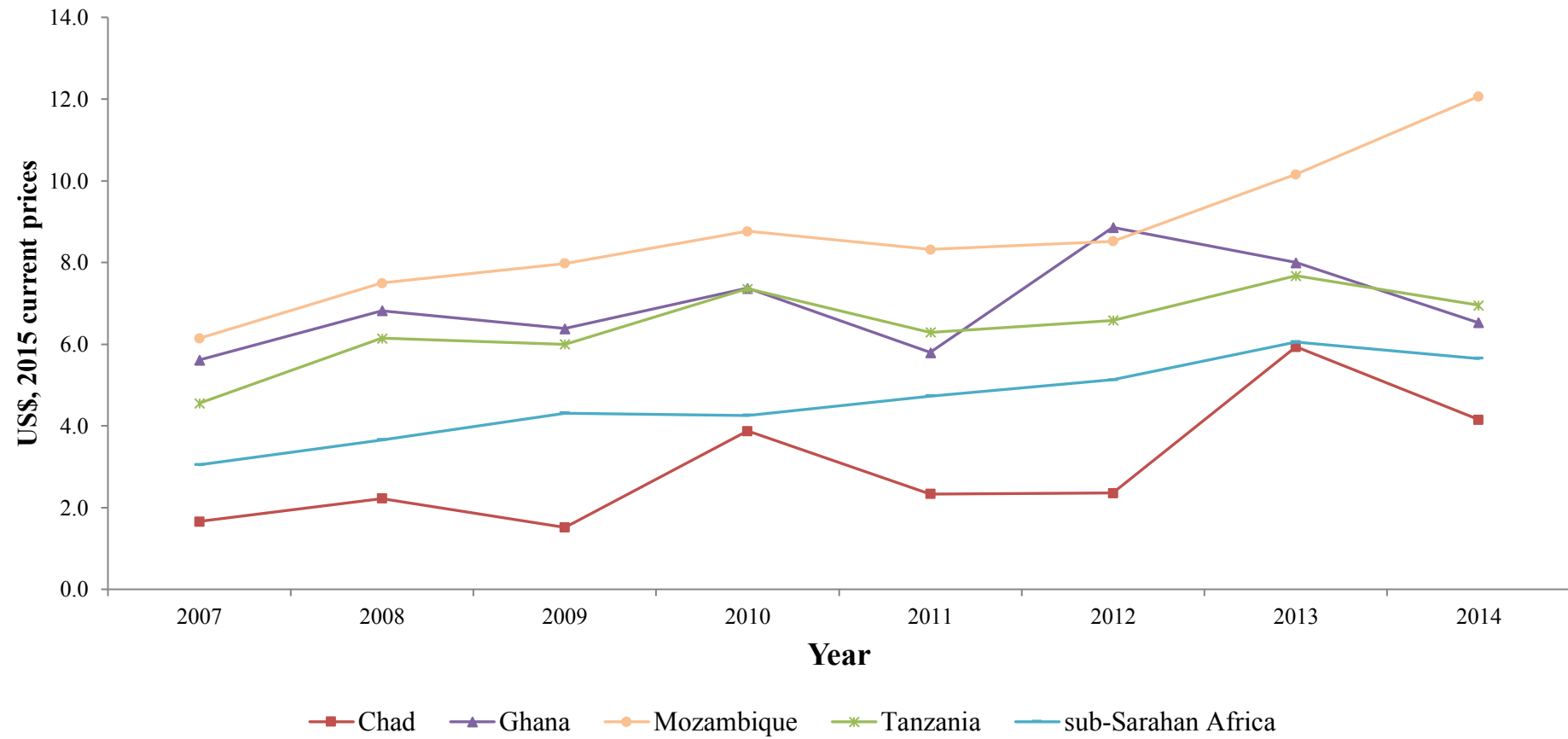


Figure 12. ODA for health per capita, disbursements

Based on World Bank Population estimates, 2015 (The World Bank, 2016) and OECD ODA CRS statistics (OECD, 2016g)

Overall, Mozambique and Tanzania rely more heavily on external resources for health than Chad and Ghana (Figure 13). It is unclear why Tanzania's degree of reliance on external finance for health varies so much from year to year while ODA for health per capita, government expenditure for health as proportion of total spending, and its economy are relatively stable.

The composition and disbursement size of health development actors in the countries also vary (Table 12).

As of 2010, Chad had 20 sources of ODA for health (9 bilateral, 11 multilateral) and six of them disbursed less than US\$1 million (WHO, 2012a). At the other extreme, Mozambique had 31 sources (20 bilateral, 11 multilateral) and only six disbursed less than US\$1 million (WHO, 2012c).

All of these elements culminate in varied and dynamic health financing landscapes at the country-level. These statistics only account for official development assistance and do not capture flows from philanthropic foundations, corporate social responsibility programs, or any of the emerging economies, including the BRICS.

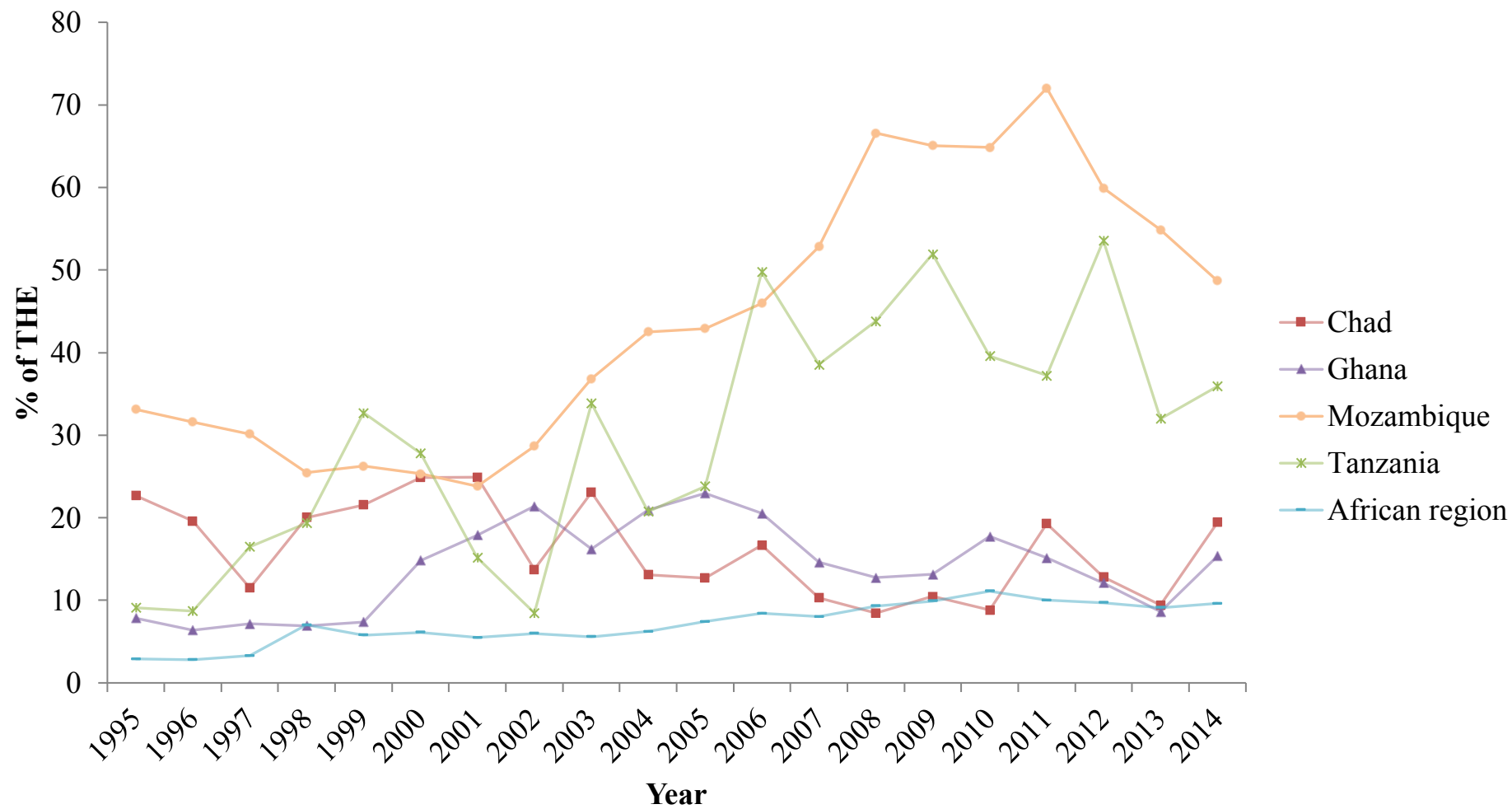


Figure 13. External resources for health (percent of total expenditure)  
(WHO, 2016b)

*Table 12. Top 5 sources of disbursements for health, case-study countries (2009-2010)*

<b>Chad</b>		<b>Ghana</b>		<b>Mozambique</b>		<b>Tanzania</b>	
<b>Source</b>	<b>%</b>	<b>Source</b>	<b>%</b>	<b>Source</b>	<b>%</b>	<b>Source</b>	<b>%</b>
the Global Fund	37.8	the Global Fund	27.5	United States	43.4	United States	41.0
UNFPA	12.6	United States	17.5	the Global Fund	10.0	the Global Fund	19.3
UNICEF	9.1	United Kingdom	12.1	Ireland	5.6	IDA	9.3
GAVI	7.7	Netherlands	10.9	United Kingdom	4.8	Germany	4.8
EU Institutions	6.1	Denmark	10.1	Canada	4.7	Denmark	4.4

(WHO, 2012a, WHO, 2012b, WHO, 2012c, WHO, 2012d)



### 3.2 Primary data collection

Data was collected as part of a larger study on the influence of emerging donors in health development (SNIS, 2012). For the purpose of the larger study “emerging donors” includes philanthropic foundations, corporate social responsibility programmes, public-private partnerships, Brazil, Russia, India, China, South Africa, and other emerging economies. Private sources of finance were defined as philanthropic foundations and corporate social responsibility programmes (CSR). Investigators conducted face-to-face semi-structured in-depth interviews with 88 key informants from the Ministry of Health, Ministry of Finance, health or development attachés of partner embassies in-country, selected UN agencies, local research institutions, the African Development Bank, and independent consultants. Interviews were held in the offices of key informants in N’Djamena, Chad; Accra, Ghana; Maputo, Mozambique; and Dar es Salaam, Tanzania. One in-depth interview was conducted by Skype. Interviews lasted approximately one hour but ranged from 45 minutes to three hours. Interviewers held an additional five brief discussions with relevant experts for country and/or development context (Table 10). In N’Djamena investigators were invited to, and attended, a meeting hosted by the Country Coordinating Mechanism (the partnership of local stakeholders responsible for Global Fund grant development, submission, and, upon approval, oversight).

Investigators contacted prospective interviewees via email. We obtained email addresses through professional contacts and government websites. Emails contained a brief description of the research team, overall research questions and objectives, and methods. Respondents suggested additional interviewee(s) who were then contacted directly by the research team.

Interviews in Ghana and Tanzania were conducted in English. In Chad, ten interviews were conducted in French and six in English. The meeting of the Country Coordinating Mechanism was held in French. One investigator is a Francophone and the other an Anglophone (accompanied by a local translator). In Mozambique discussions were held primarily in English with periodic clarifications in Portuguese as one investigator speaks Portuguese fluently. Investigators took detailed notes during the discussion. When more than one investigator was present for an interview, notes were compared after transcription.

*Table 13. Interviewees by institution*

	Academic Institutions	Consultants	Coordination Bodies	Government Officials	Multilateral Institutions	NGOs	OECD partners	Total
Chad	0	4	2	4	9	1	4	24
Ghana	1	1	2	4	6	3	0	17
Mozambique	0	2	2	2	6	2	11	25
Tanzania	3	2	0	5	7	0	10	27
<b>Total</b>	<b>4</b>	<b>9</b>	<b>6</b>	<b>15</b>	<b>28</b>	<b>6</b>	<b>25</b>	<b>93</b>

\*includes face-to-face interviews, Skype call, and four respondents added in follow-up emails with MZ and TZ

Interviewers used a semi-structured interview guide (Annex 1). Discussions included questions about interviewees' perspectives on overall changes in development assistance for health and resulting influences at country-level. Interviewers sought perceptions about who were the most influential private sources of finance and knowledge of actors' activities in-country. Interviewers asked open-ended questions about private actors' engagement with other donors, the recipient government, and their prospective roles in the country's health development landscape.

Key informants in Tanzania received follow-up emails eleven months post-interview to ascertain relevant changes in the donor landscape. Eleven interviewees responded and two referred the investigators to new respondents. Key informants in Mozambique received follow-up emails nine months after the initial interview. Again, eleven responded and two referred the investigators to new respondents who provided input.

### 3.3 Analysis

The corresponding author combined interviewers' notes into one Microsoft Word document per interviewee and organized the material into fundamental themes- type of donor, aid management, health system, country context, etc. The corresponding author uploaded interview notes into MAXQDA 11 (UdoKuckartz; Berlin, Germany) and read each at least three times. Each successive reading was accompanied by descriptive, analytic, and thematic coding, respectively.

Chapter 4 *Stakeholder perceptions in sub-Sahara Africa of private assistance for health and principles of aid effectiveness* - Thematic coding revealed that discussions fit within the Paris Declaration Framework, i.e. the five pillars of ownership, alignment, harmonization, managing for results, and mutual accountability.

Chapter 5 *Engaging with emerging economies for health development: a case-study of four sub-Sahara African countries* – Interviews were coded by donor country and sub-themes were identified. Thematic codes revealed common strengths and challenges of working with emerging economies.

Chapter 6 *The Global Fund's paradigm of oversight, monitoring, and results in Mozambique* – Coding revealed that discussions centered on the Global Fund paradigm (governance and

structures), its approach to monitoring results, and partnerships with other donors. A framework was created to cover these elements of the Global Fund - recipient relationship.

Interview notes were indexed using the respective frameworks and included sub-themes as determined by the initial analytic coding (Gale et al., 2013).

To maintain respondents' anonymity, each interviewee was given a label: two letter country code, professional affiliation, and number (based on chronological order of interviews of people with same professional affiliation). For example, "TDConsultant2" the second consultant interviewed in Chad.

#### 4. Stakeholder perceptions in sub-Saharan Africa of private assistance for health and principles of aid effectiveness

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Submitted to **International Journal of Health Policy and Management**

## 4.1 Abstract

Development assistance for health (DAH) has increased substantially in the last 15 years, and the global health landscape continues to evolve into an increasingly complex network of actors and institutions. Overall, private capital flows are now the largest portion of finance from developed countries to developing countries, but it is unclear how much of this is DAH. The influence of increasing plurality of the global health financing system on the coherence, efficiency, and effectiveness of health development programmes requires further investigation. In this paper we report results of the influence of private donors on health development in Chad, Ghana, Mozambique, and Tanzania- four countries that span the donor-darling / donor-orphan spectrum. We conducted face-to-face semi-structured in-depth interviews with 93 key informants from government ministries, bilateral and multilateral agencies, local research institutions, and independent consultants. Thematic coding revealed that discussions on private donors fit within the Paris Declaration Framework, i.e. the five pillars of ownership, alignment, harmonization, managing for results, and mutual accountability. Small-scale engagement makes harmonization more difficult and more necessary, but private actors are absent from coordination groups at the country-level. Therefore development partners know little of how private actors are engaged in the health sector. Private finance for health is not necessarily aligned with country priorities or strengthening country health systems. This type of assistance is complementary to conventional bi- and multi-lateral assistance, but in order to limit further fragmentation, emerging donors should be informed of, and included in, development partner group discussions.

### Key words

Development assistance for health ; philanthropy ; corporate social responsibility ; Paris Declaration ; aid effectiveness

## 4.2 Introduction

Development assistance for health (DAH) has increased substantially in the last 15 years, and the global health landscape continues to evolve into an increasingly complex system of actors (Kickbusch and Szabo, 2014). For example, more than 100 well-endowed global health initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, have been established (Samb et al., 2009) since 2000. Across all sectors, private capital flows have become the largest portion of financial flows from developed countries to developing countries (Adelman et al., 2011). It is unclear how much of this private investment from remittances, philanthropic groups, and other capital resource transfers is motivated by development concerns, and how much of that is DAH.

Although global health initiatives have become the archetype for development assistance for health at country level, there is a notable growth in the number of major philanthropic foundations (with the Bill and Melinda Gates Foundation as the predominant example). Furthermore, corporations have developed corporate responsibility programmes, and there are drug donation programmes, spontaneous individual contributions to humanitarian emergencies, and international aid campaigns (Stoianova, 2012).

In 2005 more than 100 developed and developing countries agreed upon five principles of aid effectiveness in the Paris Declaration - ownership of development policies and strategies, alignment of aid with country priorities and systems, harmonization of donor practices, managing for results, and mutual accountability (OECD, 2005). In 2011, at the Fourth High Level Forum on Aid Effectiveness, in Busan, South Korea, development partners agreed to update the five aid effectiveness principles. Analogs of the Paris Declaration pillars of ownership, managing for results, and mutual accountability were carried forward, but alignment and harmonization were replaced by “inclusive development partnerships”. The most noticeable deletion is language about alignment of resources with national strategies (Fourth High-Level Forum on Aid Effectiveness, 2011).

The 2014 Global Partnership on Effective Development Cooperation High-Level meeting in Mexico was the first high-level discussion on aid effectiveness that included private stakeholders (Partnership for Effective Development Cooperation, 2014). In the report for the Third International Conference for Financing for Development in July 2015, participants acknowledged the contributions from philanthropists but called for increased transparency,

accountability, and alignment with country strategies and systems (OECD NetFWD, 2014). There was no mention of coordinating efforts with other actors.

With the global financial crisis, many began to question the effects of a long-term recession on development and identified potential corrective actions (Over, 2009, Batniji and Woods, 2009, Garrett, 2009, USAID, 2009). Others insisted the global recession would be unlikely to affect bilateral levels of DAH (Stuckler et al., 2011c). Years later the discussion persists, while treatment programmes have been discontinued, and aid revenue decreased (Bennett, 2012, Gravier-Rymaszewska, 2012, IHME, 2011, Dieleman et al., 2016). Likely the overall ratio of private to public spending will continue changing at a noteworthy rate.

In 2014, corporations provided \$662 million (1.9%) for DAH. Other private sources amounted to \$2.7 billion (7.4%) of DAH; this figure includes charitable giving and philanthropy excluding the Bill and Melinda Gates Foundation (IHME, 2015). 74.8% was provided to NGOs in 2014 (\$2.5 billion); UN agencies and the Global Fund also received shares. The Bill and Melinda Gates Foundation (BMGF) is the largest single source of private finance for global health. In 2014 alone, the BMGF accounted for 8.1% of total DAH and 46.6% of private funding flows for global health (\$2.9 billion USD) (IHME, 2015). Overall, private philanthropy has grown more substantially than corporate donations over the last decade (IHME, 2015). Despite the inclusion of private actors in recent aid effectiveness discussions, few philanthropic actors appear to be aware of the principles first outlined in 2005 (OECD, 2005). BMGF is the only foundation that currently adheres to the principles outlined by the 2011 Busan Partnership for Effective Development Cooperation (UNDP, 2014).

From 2003, sub-Saharan Africa consistently received the largest share of DAH. On average, it accounts for more than 24.5% of total international expenditure on health from 2000 to 2012. The vast majority of its support comes from governments, multilateral agencies, and partnerships such as the Global Fund and the GAVI Alliance (IHME, 2015). It is difficult to tease out how much support comes from private sources as they enter recipient countries through other channels, ex. NGOs. The majority of money coming from private foundations and corporations is deemed unallocatable. The only private foundation that was tracked from source to recipient was the BMGF which allocated 25.3% of its funds to sub-Saharan Africa in 2012 (IHME, 2015).

Shared roles and responsibilities blur the division between the private and public sectors' aims and responsibilities (Buse and Walt, 2000). This raises concerns about legitimacy,



accountability, and international cooperation (Hein and Kickbusch, 2010b) as well as concerns over potential conflicts of interest (Stuckler et al., 2011a), divergence from national strategies, and lack of harmonization among donors (Piva and Dodd, 2009). The influence of increasing plurality of the global health financing system on the coherence, efficiency, and effectiveness of health development programmes requires further investigation (McCoy, 2012). In this paper we report results of the influence of private donors on health sector development in Chad, Ghana, Mozambique, and Tanzania- four countries that span the donor-darling / donor-orphan spectrum (Van de Maele et al., 2013). Chad is classified as a “donor orphan”; it is ranked in the bottom 10 countries in terms of commitments and disbursements of DAH based on the OECD’s Development Assistance Committee’s credit reporting system (DAC CRS). Using the same indicators, Mozambique is classified as “donor darling”. Likewise, Tanzania is classified as a darling using the Global Health Expenditure Database. Ghana falls between a darling and an orphan across all three classifications (Van de Maele et al., 2013).

### 4.3 Methods

#### *Primary data collection*

Data was collected as part of a larger study on the influence of emerging donors in health development (SNIS, 2012). For the purpose of the larger study “emerging donors” includes philanthropic foundations, corporate social responsibility programmes, public-private partnerships, Brazil, Russia, India, China, South Africa (the BRICS), and other emerging economies. Private sources of finance were defined as philanthropic foundations and corporate social responsibility programmes (CSR). Investigators conducted face-to-face semi-structured in-depth interviews with 88 key informants from the Ministry of Health, Ministry of Finance, health or development attachés of bi- and multilateral agencies, local research institutions, the African Development Bank, and independent consultants. Interviews were held in the offices of key informants in N’Djamena, Chad; Accra, Ghana; Maputo, Mozambique; and Dar es Salaam, Tanzania. One in-depth interview was conducted by telephone. Interviews lasted approximately one hour but ranged from 45 minutes to three hours. Interviewers held an additional five brief discussions with relevant experts for country and/or development context (Table 14). In N’Djamena investigators were invited to, and attended, a meeting hosted by the Washington, D.C.-based Grant Management Solutions (a USAID-funded technical body founded to support Global Fund principle recipients (GMS, 2016)).

*Table 14. Interviewees by institution*

	Academic Institutions	Consultants	Coordination Bodies	Government Officials	Multilateral Institutions	NGOs	OECD partners	Total
Chad	0	4	2	4	9	1	4	24
Ghana	1	1	2	4	6	3	0	17
Mozambique	0	2	2	2	6	2	11	25
Tanzania	3	2	0	5	7	0	10	27
<b>Total</b>	<b>4</b>	<b>9</b>	<b>6</b>	<b>15</b>	<b>28</b>	<b>6</b>	<b>25</b>	<b>93</b>

\*includes face-to-face interviews, telephone call, and four respondents added in follow-up emails with MZ and TZ

We contacted prospective interviewees via email. We obtained email addresses through professional contacts and government websites. Emails contained a brief description of the research team, overall research questions and objectives, and methods. Respondents suggested additional interviewee(s) who were then contacted directly by the research team.

Interviews in Ghana and Tanzania were conducted in English. In Chad, ten interviews were conducted in French and six in English. The meeting of the Country Coordinating Mechanism was held in French. One investigator is a Francophone and the other an Anglophone (accompanied by a local translator). In Mozambique discussions were held primarily in English with periodic clarifications in Portuguese as one investigator speaks Portuguese fluently. Investigators took detailed notes during the discussion. When more than one investigator was present for an interview, notes were compared after transcription.

We used a semi-structured interview guide (see Annex 1). Discussions included questions about interviewees' perspectives and experiences of overall changes in development assistance for health and resulting influences at country-level. Interviewers sought perceptions about who were the most influential private sources of finance and knowledge of actors' activities in-country. We asked open-ended questions about private actors' engagement with other donors, the recipient government, and their prospective roles in the country's health development landscape.

Key informants in Tanzania received follow-up emails eleven months post-interview to ascertain further developments in the donor landscape. Eleven interviewees responded and two referred the investigators to new respondents. Key informants in Mozambique received follow-up emails nine months after the initial interview. Again, eleven responded and two referred the investigators to new respondents who provided input.

### *Analysis*

The corresponding author combined interviewers' notes into one Microsoft Word document per interviewee and organized the material into fundamental themes- type of donor, aid management, health system, country context, etc. These were uploaded into MAXQDA 11 (UdoKuckartz; Berlin, Germany) and read each at least three times by the corresponding author. Each successive reading was accompanied by descriptive, analytic, and thematic coding, respectively. Thematic coding revealed that discussions fit within the original Paris Declaration Framework, i.e. the five pillars of ownership, alignment, harmonization, managing for results,

and mutual accountability. Interview notes were indexed using the framework and included sub-themes as determined by the initial analytic coding (Gale et al., 2013).

To preserve respondents' anonymity, each interviewee was given a label: two letter country code, professional affiliation, and number (based on chronological order of interviews of people with same professional affiliation). For example, "TDConsultant2" the second consultant interviewed in Chad.

## 4.4 Results and Discussion

### *Overview in case-study countries*

Despite the marked increase in private finance for health, discussions with health ministry officials and development partners at the country-level painted a different picture. Many interviewees concluded that although private actors work in these countries, their contributions are not visibly influential in the health sector. For example, government interviewees had heard of private financiers acting in Chad but had *never seen any outcome* of their activities (TDGovernment2). Respondents in all four countries perceive foundations and CSR programmes to have a narrow scope and provide one-off project assistance. In Chad and Ghana, interviewees commented that support from private actors has been increasing and that this trend will likely continue. One interviewee from Chad drew from his experience in other contexts and suggested that economic transitions present openings for unconventional financiers (TDConsultant1). This could also apply to Mozambique where foreign direct investment, government revenue, and lending, have all increased, changing the balance and influence of traditional donors.

Private financiers are seen to be complementary sources of finance. Their contributions are welcome due to financial challenges, but they contribute to fragmentation and do not feed their experience back into their aid approaches. Overall, interviewees' observations and concerns about the influence of private assistance were consistent with the themes outlined in the Paris Declaration, particularly alignment and harmonization of assistance.

### *Alignment*

Alignment refers to coherence of support with recipient countries' development strategies and policies, as well as strengthening country systems (OECD-DAC, 2009). Philanthropic foundations' priorities and strategies differ from bilateral donors because they are determined more by *internal* factors than *external* factors. The interests of the benefactors, donors, or Board members dictate the priorities and therefore the themes of funding (Adelman et al., 2011).

Regardless of how the different types of organizations develop their strategies, respondents largely agreed that private sources of assistance are not adhering to the principles of alignment in their respective countries. *Like the larger funders, these sources tend to want to impose their own agendas* (TZAcademic1).

Overall, interviewees agreed that resources coming from philanthropic sources are complementary to conventional development assistance, but replacement isn't feasible due to the narrowly-focussed approach. Respondents in Tanzania highlighted the pros and cons of philanthropic foundations' lack of alignment with national strategies. One interviewee implied that foundations' agendas are ideological rather than needs-based, e.g. Kaiser Foundation (USA), *...because of the sensitivity of donors, [some] private sources are reluctant to channel funds to the critical HIV-infected groups* (TZMultilateral5). On the other hand, when the donor is more liberal than the government and doesn't need to worry about political diplomacy, it can fill gaps. *The Diana Foundation (UK-based) provides funding for HIV/AIDS to fill gaps left by government due to systemic stigma (e.g. criminalization of certain behaviors that result in increased risk for AIDS – sex workers, men-who-have-sex-with-men)* (TZMultilateral5).

Systems support was a prominent theme of discussions in Chad and Tanzania. In both countries there were discordant views on systems support from the BMGF. In Chad one respondent recounted that along with polio eradication, BMGF also strengthens routine immunization (TDConsultant1). TDConsultant2 stated that BMGF, *understands there is need for a fully functioning health system*. In contrast, a third respondent spontaneously implied that BMGF provides no system-level support, *Gates should do minimum of training and capacity development. Without adequate health systems, even if funded by Gates, medication will not be used efficiently; there will be losses due to mismanagement* (TDMultilateral9). In Tanzania the debate centered upon the Clinton Health Access Initiative which is under the umbrella of the Clinton Foundation. Its projects are included in the Health Sector Strategic Plan, and to that extent are approved by the government (TZMultilateral3). Likewise, *they are involved in collaborations for the pay-for-performance scheme, innovative financing mechanisms, and systems strengthening* (TZOECDPartner4). Another respondent addressed the same area of support but with a different opinion. *They are very active in terms of money and technical input, but they are following their own agenda. They set up a pay-for-performance scheme over the past two years and trying to influence policy although the government is not ready to commit to a certain type of payment scheme* (TZOECDPartner3). This intervention was a source of conflict within the development partners group for health (Chimhutu et al., 2015).

In Chad and Tanzania, it is difficult to know what causes this discordance. Is the disagreement because different respondents / organizations define systems strengthening differently? Also, was this topic discussed more frequently because there was a dominant actor in both countries - BMGF and Clinton Foundation, respectively? Neither Ghana nor Mozambique had a similarly visible source of private funding. Is the health system strengthening debate on development actors' minds because private actors who are so visible are now being held to similar standards as conventional donors? In the case of the Clinton Foundation in Tanzania, this debate is particularly interesting as it works alongside the health ministry, and all of its projects are included in the Health Sector Strategic Plan. So although they fully align on paper, there is disagreement about who exactly is dictating the strategy.

In Chad, Mozambique, and Tanzania CSR contributions are small-scale projects with limited reach. Interviewees identified the extractive industries, namely oil and gas, as the most visible contributors through CSR. In general, these programmes are not focused on the long-term, are localized, and target personal interests. Due to lack of evaluation, it is difficult to gauge how much they provide in the short-term (MZGovernment1). As one respondent said, *The private sector is better suited for one-off commitments rather than sustained contributions* (MZNGO2).

Ghana has a unique example of a CSR programme that has been incorporated into a national strategy. Presently, AngloGold Ashanti is a Principle Recipient of a Global Fund grant for a malaria control programme in 40 districts. It was replicated on AngloGold's integrated malaria programme for employees in Obuasi town and villages of the Obuasi Municipal district. Some respondents were not particularly supportive of the programme - though they have experience and success in a small locality, they do not necessarily have the technical capacity to scale-up to national level. Overall, CSR programmes have contributed minimally. *AngloGold Ashanti Malaria Control Ltd is an exceptional case, and its formation and level of involvement is due to Global Fund support* (GHGovernment3).

Although respondents gave mixed reviews about private actors working within the national strategy, they are some of the first of their kind and could provide models for the future. Realistically, donors will only provide coherent and cohesive support if governments are clear about what they want, spell out their policies, and forge meaningful strategies to act as a framework for all domestic and donor resources. Governments must also ensure compliance with their own strategies and hold private sector to the same alignment standards used for official development assistance for health.

### *Harmonization*

Harmonization, has three principles- coordinated donor actions, simplified procedures, and shared information to avoid duplication (4). The World Bank, for instance, emphasizes harmonization with key stakeholders in order to organize aid initiatives and finances for the health sector (Yiu and Saner, 2011). In-country coordinating bodies are a response to the Paris Declaration. They are comprised of bilateral and multilateral agencies that work with the host government and domestic non-governmental stakeholders for increased coordination and health development effectiveness.

In 2014, the OECD Global Network of Foundations Working for Development (netFWD) developed the “Guidelines for Effective Philanthropic Engagement” (OECD NetFWD, 2014). The three pillars- dialogue, data / knowledge sharing, and partnering- aim to foster “mutual recognition between philanthropic actors, governments and development agencies on the basis of their respective comparative advantages” (Samb et al., 2009). Essentially, this document reflects the recognition of the Paris Declaration’s harmonization pillar as the foundation of effective engagement. One could assume that all organizations associated with netFWD would abide by this pillar, if none other. Therefore it is surprising that the only foundation adhering to the 2011 Busan Partnership for Effective Development Cooperation principles was BMGF (Adelman et al., 2011). Although the Busan Agreement does not explicitly address harmonization, foundations’ adherence would symbolize their commitment to internationally recognized principles. Currently many philanthropic foundations neglect systematic reporting of interactions with governmental institutions and other donors operating in-country (Nam et al., 2013).

All four case-study countries have active country-level coordinating bodies. Interviews highlighted a distinct absence of private actors in these mechanisms.

In Chad, new partners are expected to enter the health sector in the established partnership framework, but so far it is unclear with whom private actors engage. They lack structured policies and focus areas. TDGovernment4 stated that *[t]here are difficulties in coordinating both conventional and unconventional donors, but it is essential for all to coordinate* (TDGovernment4). The government convenes meetings once per month to promote dialog with donors. Private partners have not been included in coordination bodies led by conventional development partners, but

*The partners group is very formalized and technically open to all, but to-date there is no clear criteria for representation. The group of development partners has acted somewhat exclusively by not extending the invitation to join to interested, potential partners. So the dialog has been stymied. Involvement of non-traditional partners is weak perhaps because they are not well-informed or perhaps because they are not pro-active (TDMultilateral1).*

In terms of CSR specifically, one respondent reported that *the results of their efforts are unclear, there are no observers, and there is no cooperation (TDCoordination1).*

In Ghana, respondents were more likely to mention *channels* for private contributions such as the Global Fund or the One Million Community Health Workers Initiative<sup>1</sup> rather than philanthropic actors. Such partnerships can obfuscate the contributions of different actors from the recipient's perspective. There was a remarkable increase in resources coming from CSR programmes in 2012, but perhaps the data are being captured more effectively rather than an actual increase (GHGovernment4). Respondents discussed a diverse group of corporate actors in Ghana- banks, the Cocoa Board, mining companies, oil and gas companies, and telecommunications providers. Ghana's lack of policy for integrating CSR funds has resulted in uncoordinated activities and, ultimately, waste. *The Central Medical Stores currently has medicines that will not be distributed but must be disposed of. These medicines were likely purchased without regard to context or need (GHGovernment2).* The Ministry of Health is working towards a policy for including the private sector because of these coordination challenges.

One development partner in Tanzania argued that participation in coordination activities through the Development Partners Group is not always for the sake of coordination. *Clinton is the only private foundation participating regularly, albeit opportunistically, in the sector-wide approach. They contribute to discussions only to push their agenda rather than moving forward together as a group (TZOECDPartner3).* With regard to harmonization of actual funds, private actors do not provide finance to the sector-wide approach basket because of the lack of visibility and lack of "branding" (TZOECDPartner3).

One interviewee in Mozambique best summarized coordination with corporations in the health sector. *So far this type of support is uncoordinated, and there is no real model. It is actually Corporate Social (Ir)responsibility (MZMultilateral2).* Respondents often spontaneously listed

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<sup>1</sup> <http://1millionhealthworkers.org/> "The 1mCHW Campaign, which has a partnership base of over 150 organizations from United Nations agencies, civil society, the private sector, and academia, was launched in January 2013 at the World Economic Forum in Davos. Since its launch, the Campaign has been actively supporting African governments and partners who are dedicated to increasing the number and quality of lay health workers in the region."



philanthropic donors, but not corporations, working in project implementation. This suggests that philanthropic donors are more likely to partner up- either out of necessity or by choice. This could result from the fact that they do not have institutional memory as donors (MZGovernment1).

Respondents largely agreed that the small scale at which these donors operate makes it even more important for them to coordinate their efforts with established donors to maximize and leverage their assistance. This could be especially important for philanthropic donors who work in multiple locations. In theory, this makes philanthropic foundations perfect candidates for utilizing and supporting national systems (and therefore avoiding duplication). CSR programmes are quite localized, so perhaps they do not feel the need to use more country systems.

#### *Mutual accountability*

Models of ‘mutual accountability’ between donors and recipients inherently vary between countries as recipient mechanisms for aid delivery are fundamentally different. For example, respondents in Chad reported that no donor funds go through the government. In Tanzania official development assistance always goes through the Ministry of Finance. Ghana and Mozambique both have more mixed models; their governments do receive funds from donors, but these funds can enter at any level (central, regional/provincial, or district), and many actors act outside of government channels altogether (de Savigny et al., 2012). Therefore, although the underlying principles of mutual accountability should remain consistent across the countries, the means for achieving this goal will naturally vary. At the time of the interviews all four case-study countries lacked policies for integrating resources from private donors but recognized the need to formalize guidelines. Additionally countries experience a lack of mutual transparency, whether it was on the part of the government(s) or the private actors. This has direct implications for mutual accountability.

In Chad, BMGF is the largest philanthropic donor and communicates with the Ministry of Health through either UNICEF, WHO, or the Chadian Comité de Coordination Inter-agences. The Ministry of Health is uninformed of BMGF activities in Chad, unless *Bill Gates himself comes to Chad for a meeting* (TDGovernment4). The Ministry of Health and development partners disagreed about who private actors were coordinating with. The ministry said that they had little to no contact with foundations and corporations. Interviewees from development agencies reported that, so far, these newer actors only coordinated with the ministry.

Despite private actors' absence in coordination bodies, in Tanzania development partners seemed very aware of private actors and partnerships between organizations. Most would spontaneously offer a litany of health development projects, all organizations involved, and where they were located. All interviewees were involved and actively engaged in the Development Partners Group, and it was clear that there was continuous communication among the OECD Partners. Any lack of awareness of the development partners must stem from insufficient communication from the government. Tanzania's operations are decentralized, but unlike Ghana health is governed at the national level, and all external actors must act under the auspices of the Ministry of Health (de Savigny et al., 2012).

*There is an overall sense of uncertainty of volume of funding from different sources outside the Development Partners Group for health. This is not communicated openly. Submitting reports to the Ministry of Finance is mandatory for conventional donors, but is voluntary for unconventional sources (TZOECDPartner5).*

TZOECDPartner1 shared that it is not uncommon to arrive at the launch of a project only to discover a previously unknown organization doing similar work in the same location- all sanctioned by the government. Additionally, the Ministry of Health reported that support from extractive industry goes directly to health facilities and hospitals. This indicates a different standard to which industry is held. All official development assistance for health is required to be channelled through the Ministry of Finance.

In Mozambique, there is no reported coordination between corporations and the Ministry of Health, and it was suggested that they actually contribute to brain drain as they hire people from the ministry. These discussions rarely included direct commentary on who should be held accountable in preventing brain drain. Only one respondent was quick to state that *it is the onus of the government to regulate the extractive industry* (MZMultilateral2). The government has proposed innovative health financing strategy for 2019, but there is a gap in rhetoric versus reality for integrating private resources. Multiple interviewees converged on the idea that *the best thing that the private sector could do, including the extractive industry, is pay taxes. The revenue generated through fair taxing would far outweigh any contribution they would make through a corporate social responsibility programme* (MZOECDPartner7).

One respondent, MZMultilateral6, highlighted another gap in progress towards satisfactory accountability of both donors and recipient governments- transparency. Until transparency extends to civil society, it will be difficult to gauge whether or not decision-makers on either side of a partnership are being held truly mutually accountable.

### *Managing for results*

Managing for results refers to a management strategy for increasing efficiency and effectiveness with an emphasis on shared values and leadership while promoting results-based decision-making. It is an approach that includes strategic planning, monitoring and evaluating performance, reporting, and incorporating lessons learned for improvement (Buse and Walt, 2000). Overall respondents discussed “managing for results” very minimally with regard to private donors, and when they did it was interwoven in discussions that centered more heavily upon other pillars.

Discussions with TDMultilaterals 9 and 10 highlighted the role of alignment with country systems to increase results. Likewise, in Tanzania, TZMultilaterals 1 and 2 were under the impression that because private sources don’t have a local base, *they are not feeding back their experience into their aid approaches*. Other respondents in Tanzania suggested that a key to producing results had more to do with scale rather than alignment or evidence-based decision-making. *Private financing sources like Clinton Foundation and Gates’ Foundation support projects which can show results rather than larger programmes* (TZMultilateral3).

Overall, respondents’ comments in Chad and Mozambique reflect that the lack of harmonization with CSR programmes leaves respondents without much to say about whether and how they measure up to the managing for results pillar:

*It is difficult to predict how important corporate social responsibility programmes will be for health development over the coming years because the results of their efforts are unclear, there are no observers, and there is no cooperation* (TDCoordination1).

*In general, these programmes are not focused on the long-term, they are very localized, and it is difficult to gauge how much they actually provide in the short-term* (MZGovernment1).

As private actors’ lack of harmonization was the most pervasive theme, it is not surprising that respondents did not spontaneously discuss the emerging donors’ results or management thereof. Both conventional development partners and government officials were largely unaware of the nature of these actors’ engagement (as compared to awareness of conventional partners’ efforts), so it is unlikely that they should speak of organizational policies on results management.

### *Ownership*

The first pillar of the Paris Declaration, national ownership, refers to developing countries setting their own development strategies, improving their institutions, and tackling corruption (OECD-DAC, 2009). Respondents in all four case-study countries commented on their respective country's lack of policy for including emerging donors, but the governments are actively discussing developing such policies and more inclusive health financing strategies. Interviewees often commented on perceived weaknesses in the health system but not specifically in the context of external private finance. Therefore these comments were deemed irrelevant in this analysis. The theme of country ownership was most often woven into interviewees' opinions about the future of private finance for health in Ghana and Mozambique. Each of the case-study countries has a unique relationship with philanthropic foundations and corporations who support health development, but they also share experiences in terms of adherence to the Paris Declaration (Table 15). Respondents expressed similar concerns and hopes for future collaboration with private donors.

*Table 15. Summary of private donors' adherence to the five Paris Declaration pillars*

	<b>Alignment</b>	<b>Harmonization</b>	<b>Mutual accountability</b>	<b>Ownership</b>	<b>Managing for results</b>
<b>Chad</b>	<ul style="list-style-type: none"> <li>• discordant views on degree of systems support</li> <li>• CSR based on location of industry and personal interests</li> <li>• not focused on long-term; lacking evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• lack structured policies and focus areas</li> </ul>	<ul style="list-style-type: none"> <li>• government largely uninformed of activities</li> <li>• opposing accounts of who donors are communicating with in-country</li> </ul>		<ul style="list-style-type: none"> <li>• alignment required to increase results</li> </ul>
<b>Ghana</b>	<ul style="list-style-type: none"> <li>• private company integrated into national strategy</li> <li>• overall CSR contributing minimally</li> </ul>	<ul style="list-style-type: none"> <li>• working on policy for integrating CSR funds</li> <li>• difficulty tracking funds</li> <li>• lack of coordination results in waste</li> </ul>	<ul style="list-style-type: none"> <li>• lack of policy affects decreases accountability</li> </ul>	<ul style="list-style-type: none"> <li>• associated with discussions about private donors and effective engagement</li> </ul>	
<b>Mozambique</b>	<ul style="list-style-type: none"> <li>• CSR based on location of industry and personal interests</li> <li>• not focused on long-term; lacking evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• foundations more likely to coordinate than corporations</li> </ul>	<ul style="list-style-type: none"> <li>• disagreement about responsibility for brain-drain</li> <li>• lack of transparency</li> </ul>	<ul style="list-style-type: none"> <li>• associated with discussions about private donors and effective engagement</li> </ul>	
<b>Tanzania</b>	<ul style="list-style-type: none"> <li>• foundations' agendas are ideological</li> <li>• fill gaps left by other donors</li> <li>• discordant views on degree of systems support</li> <li>• CSR based on location of industry and personal interests</li> <li>• not focused on long-term; lacking evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• lack of awareness</li> <li>• using coordination efforts to push own agenda</li> </ul>	<ul style="list-style-type: none"> <li>• government not clearly communicating with development partners about private donors' engagement</li> <li>• government has different standards for private donors</li> </ul>		<ul style="list-style-type: none"> <li>• private donors not using evidence-based decision-making</li> <li>• positive outcomes result of small-scale projects</li> </ul>
<b>Shared amongst all four countries</b>	<ul style="list-style-type: none"> <li>• philanthropy complementary to conventional development assistance; replacement isn't feasible due to the narrowly-focussed project approach</li> <li>• follow own agenda</li> <li>• there are good examples that could provide a model for future</li> </ul>	<ul style="list-style-type: none"> <li>• all countries have established country-level coordinating bodies</li> <li>• private donors are largely absent from coordination efforts</li> <li>• small scale makes harmonization more difficult AND more necessary</li> </ul>	<ul style="list-style-type: none"> <li>• models vary by country</li> <li>• lacking transparency</li> <li>• lacking policy</li> </ul>	<ul style="list-style-type: none"> <li>• governments actively discuss developing policies to integrate private donors and more inclusive health financing strategies</li> <li>• need for health systems strengthening</li> </ul>	<ul style="list-style-type: none"> <li>• discussions tied in themes of other pillars for increasing results (specifically alignment and harmonization)</li> <li>• results unclear due to lack of coordination / communication</li> </ul>

### *Prospective*

A few respondents, particularly in Ghana and Mozambique, spontaneously gave insights into how they predict private donors will engage in the coming years and, furthermore, how they *should* engage. These comments most often overlapped with the theme of country ownership. One comment made by a respondent in Chad hinted at why country ownership is integral to the future of private sector engagement in health. He witnessed in Southeast Asia that *as the country transitioned economically, it was easier to get unconventional funding* (TDConsultant1). This observation is consistent with perspectives in Ghana and Mozambique.

In 2010 Ghana rebased its gross domestic product (GDP) calculations (Ghana Statistical Service, 2010) and transitioned overnight from a low-income economy to a lower-middle-income economy (Jerven and Duncan, 2012). This has changed its relationship with donors. Most importantly, Ghana is excluded from concessional loans from the World Bank's International Development Association, its predominant creditor for 30 years (Moss and Majerowicz, 2012). Although this change prevents it from receiving finance from poverty-targeted aid programmes of bilateral donors, it does signal a need for increased access to private investment, international capital markets, and lending from the World Bank's International Bank for Reconstruction and Development (Moss and Majerowicz, 2012). It may also open opportunities for emerging donors.

Respondents shared that there is an expected increase in the volume of assistance coming from external private financiers (GHNGO1). For example, the Global Fund's Country Coordinating Mechanism (the in-country multi-stakeholder group responsible for overseeing grant application and implementation) *has a new role in securing private funding as part of the national resource mobilization strategy* (GHCoordination2). EcoBank has committed \$3 million USD to West Africa with a deal that the Global Fund uses EcoBank as an intermediary (GHGovernment3).

The majority of comments made about the future of the private sector in health were not about assistance but rather about foreign direct investment. Ghana is anticipating a partnership in pharmaceutical manufacturing, namely with investors from China and India. GHMultilateral4 shared that the government provided a stimulus package to spur private or international investment for two to five new manufacturing plants. Three Indian companies have applied for a license. Additionally, there was a joint venture company between China and Ghana. This first China-Ghana pharmaceutical joint venture was inaugurated in 2005, with Danpong

Pharmaceuticals Ghana Ltd. as the Ghanaian partner. Eventually the Chinese partner pulled out, supposedly due to non-compliance with the joint venture contract.

In Mozambique, as the consultant in Chad suggested, *[f]oreign direct investment, government revenue, and lending have all increased which changes the balance and the influence of traditional donors* (MZOECDPartner10). A number of interviewees (MZNGO2 and MZOECDPartners 7, 8, and 9) agreed that tax regulation is important for harnessing the wealth of the private sector. Additionally, MZOECDPartners 7, 8, and 9 suggested that there is room to pilot a Development Impact Bond. MZOECDPartner4 elaborated on the perceived benefits, *It would result in a longer-term commitment, guaranteed results, and risk-sharing. It would require cooperation of government, NGOs, and private actors who have the flexibility to innovate and take higher risks. ... Also, it is more an outcome-based approach rather than an output-based approach.*

A follow-up discussion with MZOECDPartners 7, 8, and 9 revealed that the Ministry of Health says that they are open to Development Impact Bonds but view this approach as a purely donor-funded endeavor. In order for it to work, the Ministry of Health must have a clearly defined role as overseer and service provider. They must define what services they would be willing to out-source and set clear targets. Such a mechanism should be an integrated component of the national strategy. Ultimately, it is an approach to harmonization, but in theory, it addresses all five pillars of the Paris Declaration.

## 4.5 Conclusion

This four-country study revealed that there is currently little coordination among private donors and conventional development partners. Development partners know little about how, specifically, private actors including philanthropic foundations are engaged in the health sector. Due to the scale of their engagement, private donors are only complementary to assistance coming from large bi- and multi-lateral agencies. They currently contribute to fragmentation due to their narrow focus. They are not necessarily aligned with country priorities or strengthening country health systems. These unconventional donors are not held to the same standards as conventional donors in terms of regulation, policies (e.g. in Tanzania submitting reports to the Ministry of Finance is mandatory for official development assistance, but is voluntary for unconventional sources). Corporate Social Responsibility aside, perhaps the greatest contribution that could come from the corporate sector is to pay fair tax, provided the

host country has an effective anti-corruption mechanism in place. Responsibility must be taken all along the value chain, and the governance of this extends beyond the health sector.

Ten years later, health development stakeholders at country-level are still talking about Paris Declaration principles and are calling for emerging donors to adhere to the five pillars, in particular alignment, harmonization, and mutual accountability. Based on our interviews with key stakeholders, philanthropic foundations and corporations are not responding to these in-country demands. Currently, in the four case-study countries, there are no policies, there is little information available, and, therefore, there is no means for accountability. This type of assistance is complementary to conventional bi- and multi-lateral assistance, but in order to prevent further fragmentation, emerging donors should be informed of, and included in, development partner group discussions.

#### 4.6 Key messages

- Ten years after the Paris Declaration, country-level discussions still focus on alignment and harmonization of development assistance for health.
- Due to the scale of their engagement, private donors remain complementary to assistance coming from large bi- and multi-lateral agencies.
- Small-scale engagement makes harmonization more difficult AND more necessary, but private actors are absent in coordination groups at the country-level.
- Private donors are not necessarily aligned with country priorities or strengthening country health systems and currently contribute to fragmentation due to their narrow focus.

#### 4.7 Acknowledgements

The authors would like to thank all participants for their time and interest in responding to interviews and follow-up. The authors would also like to thank our gracious hosts for their support in Chad, Ghana, and Tanzania, respectively: Dr Daugla Doumagoum Moto (Centre de Support en Santé Internationale; N'Djamena, Chad), Dr. Moses Aikins (University of Ghana; Accra, Ghana), and Dr. Honorati Masanja (Ifakara Health Institute; Dar es Salaam, Tanzania). Additionally, we would like to thank Dr. Charles Mayombana for being such a helpful guide in



the halls of the Ministry of Health and the streets of Dar es Salaam and Malaba Haroun for patiently translating interviews in N'Djamena. This work was funded by the Swiss Network for International Studies (reference # 3938) and the Swiss Tropical and Public Health Institute.



## **5. Engaging with emerging economies for health development: a case-study of four sub-Sahara African countries**

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For submission to **Journal of International Development**

## 5.1 Abstract

Brazil, Russia, India, and China (the BRICS) have banded together as a bloc and launched joint initiatives for development. They have identified mutual interests, and they provide development assistance for health in their respective regions and abroad. As they do not currently report to international financial tracking data repositories, the volume, exact nature, and effectiveness of these emerging donors' engagement with recipient countries remain unclear. In this paper we report results of the influence of emerging economies on health development in Chad, Ghana, Mozambique, and Tanzania- four countries that span the donor-darling / donor-orphan spectrum. We conducted face-to-face semi-structured in-depth interviews with 93 key informants from government ministries, bilateral and multilateral agencies, local research institutions, and independent consultants. Interviewees identified health-specific engagement by the BRICS and other emerging economies. Thematic coding of interviews revealed common strengths and challenges of working with emerging economies. Overall, based on all of the interviews, BRICS do not contribute significantly to the public health sector. Interviewees see space for them in the landscape but acknowledge that myriad obstacles exist. They are not seen as a replacement, but rather as a supplement, for conventional aid. Emerging economies are not foreseen to provide assistance that resembles conventional aid; they are primarily focused on investment opportunities. Though they reportedly interact directly with the government, they are not participating in donor coordination bodies.

### **Key words**

BRICS ; emerging economies ; development assistance for health ; coordination

## 5.2 Introduction

In 2001 a Goldman Sachs economist coined the acronym BRIC (Brazil, Russia, India, and China) in his discussion on emerging market economies and the need to include them in global policymaking forums (O'Neill, 2001). South Africa was finally included in 2013 (The BRICS Post, 2013). Economists continue to argue the future of the BRICS (Washington, 2013, Avent, 2013, Nwosu, 2015) while other emerging economies vie for a spot in an expanded acronym (Aneja, 2013) or even an acronym of their own (Northam, 2014, Next 11, 2016) as they surpass some of the BRICS countries in economic growth (The World Bank, 2016). What began as a catchy phrase in an investment bank's research note has developed into a full-fledged institution complete with an arsenal of websites, think-tanks, and annual summits.

In 2014 the BRICS announced the launch of the New Development Bank (NDB). It will have an initial capital pool of US\$50 billion that will be equally divided; it will maintain a currency reserve of US\$100 billion (Panda, 2014). Its headquarters will be in Shanghai, China, and the first president will be Indian. The bank has been established, in part, to challenge the Western order maintained by the World Bank and the International Monetary Fund (Panda, 2014). The NDB will focus on infrastructure projects in developing contexts (NDB BRICS, 2016).

The 8<sup>th</sup> BRICS Summit in October 2016 was hosted in Goa, India (BRICS, 2016a). The Goa Declaration renewed its commitment to cooperate to achieve BRICS' targets for HIV and tuberculosis, including research, development, and production of drugs and diagnostics (BRICS, 2016b).

BRICS countries have individually provided foreign assistance since the 1950s (Mwase and Yang, 2012). Their contributions have increased rapidly in recent years- approximately 10 times faster than conventional donors- though the overall contributions are still relatively small in comparison to Organization for Economic Cooperation and Development (OECD) countries (Birdsall, 2012a, Tytel et al., 2012). Scholars have identified a number of trends in BRICS' development efforts such as applying principles of South-South Cooperation (G77, 2009a) focusing on partnership; avoiding policy conditionality in governance, economic policy, or institutional reform; structuring assistance to complement foreign direct investment; emphasizing individual project feasibility rather than long-term debt sustainability; and applying domestic development lessons (Mwase and Yang, 2012, Watson et al., 2013). The intention to develop their own agenda for development assistance is particularly interesting in light of the fact that their domestic health sector resource allocation appears to be still highly

influenced by current multilateral donors such as the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Sridhar and Gomez, 2011b).

While the BRICS have declared that health collaboration is a priority, they haven't yet begun working collectively to enhance the impact of their assistance programmes (Harmer and Buse, 2014). The debate on the relevance of BRICS *collective* action is ongoing (McKee et al., 2014). Of the bloc, China has contributed the largest sum of foreign assistance to low-income countries approximating US\$84 billion in 50 African countries, as of 2012 (Grépin et al., 2014). Overall, health has been a main focus of Brazil and Russia's foreign assistance agendas, while it has been less emphasized in the agendas of China, India, and South Africa (Tytel et al., 2012).

Although there are estimates on how much these countries dedicate to health, Russia is the only country that reports to the Organization for Economic Development and Cooperation – Development Assistance Committee (OECD DAC) (OECD, 2016e). Researchers speculate why the BRICS do not openly share their development assistance data and suggest the need for a more inclusive, universally applicable reporting system (Fan et al., 2014). In the meantime, tracking emerging donors for health is unreliable and prevents an understanding of the volume and influence of a growing portion of development assistance for health.

Aside from the BRICS, there are a number of non-DAC countries increasing their official development assistance. For example, the United Arab Emirates reached the highest gross national income (GNI) ratio of official development assistance (ODA) of any country at 1.17 percent (MDG Monitor, 2016). Turkey doubled its aid across sectors between 2011 and 2012 (Di Commo, 2014). In all, ODA from non-DAC providers is estimated to be between 13 and 18 percent of total ODA (OECD, 2016e, OECD Development Co-operation Directorate, 2015).

Twenty countries outside of the OECD-DAC *do* report to the OECD (OECD, 2016d). There is no data in the OECD DAC CRS showing health disbursements from Israel, Saudi Arabia, or Turkey to the four case-study countries (OECD, 2016g). On the other hand the United Arab Emirates is shown to have disbursed funds for health in Chad, Ghana, and Tanzania and Kuwait has disbursed funds to Ghana (OECD, 2016g). The relationships were not reflected in the interviews. The largest disbursement was US\$658,000 from the United Arab Emirates to Ghana in 2011.

Colombia and Mexico are among six non-BRICS, non-DAC countries for which OECD produces development cooperation estimates (OECD, 2016g). The data is not disaggregated by recipient or sector.

Currently some of these donors provide data through national reporting systems that are not formatted for cross-comparison with other donors, and for others only rough estimates are available (Steensen, 2014). Though in-country stakeholders are familiar with many non-BRICS non-DAC actors, for now the volume of assistance by sector and recipient remains unclear. Until we have more information and comparable statistics, it is impossible to evaluate the effectiveness of this assistance.

There is a growing body of literature on BRICS engagement in international development and global health diplomacy (Florini et al., 2012, Kickbusch and Szabo, 2014, Kickbusch, 2014, Gautier et al., 2014). To-date there is very little understanding of their specific activities in-country or perceptions of these countries as donors / partners (Harmer et al., 2013). In this paper we report results of the influence of emerging economies, with a particular focus on the individual BRICS, as donors for health development in Chad, Ghana, Mozambique, and Tanzania- four countries that span the donor-darling / donor-orphan spectrum (Van de Maele et al., 2013). Chad is classified as a “donor orphan”; it is ranked in the bottom 10 countries in terms of commitments and disbursements of DAH based on the OECD’s Development Assistance Committee’s credit reporting system (CRS). Using the same indicators, Mozambique is classified as “donor darling”. Likewise, Tanzania is classified as a darling using the Global Health Expenditure Database. Ghana falls between a darling and an orphan across all three classifications (Van de Maele et al., 2013).

### 5.3 Methods

#### *Primary data collection*

Data was collected as part of a larger study on the influence of emerging donors in health development (SNIS, 2012). For the purpose of this study we focus on a subset of “emerging donors”, namely, Brazil, Russia, India, China, South Africa (the BRICS), and other emerging economies. Investigators conducted face-to-face semi-structured in-depth interviews with 88 key informants from the Ministry of Health, Ministry of Finance, health or development attachés bi- and multilateral agencies, local research institutions, the African Development Bank, and independent consultants. Interviewers held an additional five brief discussions with relevant experts for country and/or development context (Table 16). The first interviews in each

country were obtained through investigators' professional contacts. We then used the 'snowball' approach whereby each interviewee suggested colleagues in partner organizations and the government who had insight into our research interests.

Interviews were held in the offices of key informants in N'Djamena, Chad; Accra, Ghana; Maputo, Mozambique; and Dar es Salaam, Tanzania. One in-depth interview was conducted by telephone. Interviews lasted approximately one hour but ranged from 45 minutes to three hours. Interviewers held an additional five brief discussions with relevant experts for country and/or development context (Table 16). In N'Djamena investigators were invited to, and attended, a meeting hosted by the Washington, D.C.-based Grant Management Solutions (technical body founded and funded by the US Agency for International Development (USAID) to support Global Fund principle recipients) (GMS, 2016).

We contacted prospective interviewees via email. We obtained email addresses through professional contacts and government websites. Emails contained a brief description of the research team, overall research questions and objectives, and methods. Respondents suggested additional interviewee(s) who were then contacted directly by the research team.

Interviews in Ghana and Tanzania were conducted in English. In Chad, ten interviews were conducted in French and six in English. The meeting of the Country Coordinating Mechanism was held in French. One investigator is a Francophone and the other an Anglophone (accompanied by a local translator). In Mozambique discussions were held primarily in English with periodic clarifications in Portuguese as one investigator speaks Portuguese fluently. Investigators took detailed notes during the discussion. When more than one investigator was present for an interview, notes were compared after transcription.

We used a semi-structured interview guide (see Annex 1). Discussions included questions about interviewees' perspectives and experiences of overall changes in development assistance for health and resulting influences at country-level. Interviewers sought perceptions about who were the most influential private sources of finance and knowledge of actors' activities in-country. We asked open-ended questions about private actors' engagement with other donors, the recipient government, and their prospective roles in the country's health development landscape.



*Table 16. Interviewees by institution*

	Academic Institutions	Consultants	Coordination Bodies	Government Officials	Multilateral Institutions	NGOs	OECD partners	Total
Chad	0	4	2	4	9	1	4	24
Ghana	1	1	2	4	6	3	0	17
Mozambique	0	2	2	2	6	2	11	25
Tanzania	3	2	0	5	7	0	10	27
<b>Total</b>	<b>4</b>	<b>9</b>	<b>6</b>	<b>15</b>	<b>28</b>	<b>6</b>	<b>25</b>	<b>93</b>

\*includes face-to-face interviews, telephone call, and four respondents added in follow-up emails with MZ and TZ

Key informants in Tanzania received follow-up emails eleven months post-interview to ascertain further developments in the donor landscape. Eleven interviewees responded and two referred the investigators to new respondents. Key informants in Mozambique received follow-up emails nine months after the initial interview. Again, eleven responded and two referred the investigators to new respondents who provided input.

### *Analysis*

The corresponding author combined interviewers' notes into one Microsoft Word document per interviewee and organized the material into fundamental themes- type of donor, aid management, health system, country context, etc. These were uploaded interview notes into MAXQDA 11 (UdoKuckartz; Berlin, Germany) and read each at least three times by the corresponding author. Each successive reading was accompanied by descriptive, analytic, and thematic coding, respectively. Interviews were coded by donor country and sub-themes were identified. Thematic codes revealed common strengths and challenges of working with emerging economies.

To preserve respondents' anonymity, each interviewee was given a label: two letter country code, professional affiliation, and number (based on chronological order of interviews of people with same professional affiliation). For example, "TDConsultant2" the second consultant interviewed in Chad.

## **5.4 Results**

### *Overview of BRICS countries*

Of the 93 interviewees, many had not heard of any of the BRICS countries engaging in the health sector or could not comment on the nature of their engagement. They were careful to distinguish between BRICS investment in the economy and their support of health-specific activities. One interviewee with a donor organisation summarized his lack of knowledge in a way that reflected the general tone in the interviews, *It is difficult to say if they aren't present, or their contributions are small enough to go unnoticed, or whether they are providing resources off-radar and therefore difficult to track* (TZOECDDPartner2). Overall, respondents agree that BRICS countries do not yet contribute significantly to the health sector in any of the four recipient countries.

Respondents who were familiar with BRICS engagement in the health sector were able to provide insight into strengths and challenges of partnering with emerging economies. Table 17 provides a comprehensive list of pros and cons as explicitly stated by respondents.

*Table 17. Strengths and challenges of engagement with emerging economies*

<b>Strengths</b>	<b>Challenges</b>
Direct interaction with Ministry of Health	Distance is an obstacle
Efficient	High transaction costs
Filling gaps left by conventional donors	Lack of accountability
Identification with the donor eases cooperation	Lack of data
More communication at higher levels	Lack of transparency
More flexible at higher levels	Language / communication issues
Quick response to requests and faster processing	No 'institutional memory'
Request and proposals less cumbersome	No systemic approach
	Not concerned with overall development
	Not coordinating through the established partner structures
	Not harmonised
	Potentially low quality investment
	Side-step international business standards
	Supply-side- and politically-driven
	Tied to commercial interests
	Time needed for contract negotiations
	Unstructured policies and focus areas

Respondents in all four case-study countries shared that emerging economies are interacting directly and exclusively with the Ministry of Health. This is particularly unique in Chad where traditional donors operate more as a network and interact with the government as a unit, oftentimes through the World Health Organization (WHO). This direct, exclusive interaction with the Ministry of Health has downstream effects on donor coordination within the recipient countries. In Mozambique, it means that the Ministry of Health finds cooperation with the BRICS much easier; they are more flexible and the process is expedited. For example, with China, it is very easy to submit requests and proposals, and the Ministry receives quick responses. With Brazil, there is more communication at higher levels and procedural flexibility. Perhaps the common Lusophone identity facilitates cooperation - the Ministry of Foreign Affairs has excellent relations with its counterpart.

Many health development actors are not enthusiastic about this type of aid because it short-circuits traditional channels. New partners are not coordinating through partner structures; they are working in parallel without necessarily knowing what is happening in the health sector. Coupled with the lack of coordination is a dearth of information; to-date South-South cooperation is not captured by national aid databases.

Tanzania is currently working with selected emerging economies on a public-private partnership project proposal for health infrastructure and medical equipment. Most conventional donors have restriction in these areas, and Tanzanian officials recognise that medical supplies without proper diagnostics impair mortality rate reduction. Therefore the BRICS are perceived as important for filling gaps left by conventional partners. Many voiced that one issue with BRICS cooperation will be efficiency versus sustainability. Perhaps China can construct a hospital with greater speed, but it is yet unknown how long will it remain in good working condition.

Though there are no insurmountable obstacles to South-South Cooperation there is no *institutional memory* like there is with long-standing partners (TZGovernment2). There will be different challenges in the relationships when compared to conventional donors; there are no systems in place, nor is there available data on working relationship, so there will perhaps be a lag in achieving results.

Many of the downsides outlined by interviewees relate to the nature of BRICS engagement. Their vast resources are needed for quick investment, but time will tell the quality of the product. Many respondents in all four recipient countries acknowledged these relationships are investment-focused and BRICS partners are perceived as working towards economic cooperation, following their own commercial interests, rather than development. Aid tied to commercial interests, and driving social questions, is not a sustainable approach for the future. BRICS involvement will reflect political culture. If there isn't a national drive for social responsibility in their own countries, they won't do it abroad either. One interviewee in Ghana (GHMultilateral2) went so far as to say, *BRICS pose the biggest threat because of their poor business practices*; there seems to be an almost organisational culture of side-stepping international standards. His examples touched on the theme of accountability, and he repeated *there is no way of tracing* to prevent fraud. Even after listing the downsides, he believes that in five to ten years, the *BRICS countries will be Ghana's largest partners in industry*. So far, structured policies and focus areas, including development effectiveness, are lacking for

unconventional donors. This highlights the importance of addressing partnership concerns upfront.

### **Brazil**

Respondents in the four case-study countries gave an account of Brazilian engagement that aligned with literature. Brazilian health assistance targets Portuguese-speaking African countries, of which Mozambique is the largest beneficiary (Russo et al., 2013). There was no evidence of Brazilian activity in Chad or Ghana. Tanzania had minimal engagement with Brazil, and Mozambique had a project profile that resembled those outlined in key papers (Russo et al., 2013, Russo and Shankland, 2014).

Brazil prefers technical assistance to conventional aid, and encourages direct interaction between Brazilian government officials and technicians and their partner-country counterparts. Trilateral agreements are a common element of Brazil's development cooperation (Russo et al., 2013); both Tanzania and Mozambique have trilateral agreements. In Mozambique, the US is the third / OECD partner while in Tanzania it is the European Union. Respondents did not know the details of the projects. Additionally, both countries benefit from Brazil's so-called 'structural cooperation in health', i.e. building local capacity for development (Almeida et al., 2010). Both countries received physician training, and Mozambique also receives training for Masters degree in health systems.

Brazil's largest contribution, in the scope of this project, is the construction and outfitting of an anti-retroviral production facility. Brazil touts the 'health industrial complex' (Russo et al., 2013, Gadelha, 2006) as an important feature of its assistance that will develop health systems and infrastructure to avoid donor dependency (Tytel et al., 2012). Unfortunately the respondent most informed on the partnership shared that there are

*...so many issues with coordination, technology transfer, staff training, patents, intellectual property, incompatibility between treatment protocols and regimes, and incompatibility with the technology that Brazil produces. We don't have the resources to make the factory work. There is incompatibility between what the factory can produce and what is needed (MZGovernment1).*

This could stem from Brazilian civil servants' lack of development-specific expertise (Russo et al., 2013). The focus on technical cooperation rather than assistance, per se, could result in inadequate evaluation and understanding of Mozambique's capacity and context.

While a couple of interviewees knew that Brazil supported the establishment of a pharmaceutical plant and physician training, a Mozambican government official was the

primary source of *specific* insights into Brazil's activities (Table 18). MZGovernment1 outlined a relationship with Brazil that aligned almost exactly with descriptions in literature, but other stakeholders seemed to be largely uninformed. This could be because of Brazil's emphasis on a true partnership with the recipient rather than being concerned about traditional donors and their coordination machinery. It might also stem from the fact that the emerging economies entered the high-level discussions on aid effectiveness with the signing of the Busan Partnership Agreement which lacks rhetoric on coordination amongst donors (Fourth High-Level Forum on Aid Effectiveness, 2011). Brazil is not documented to participate in other country-level health coordination fora (Russo et al., 2013).

### *Russia*

The literature suggests that the majority of Russia's bilateral assistance targets the Commonwealth of Independent States (CIS), is apparently steered by health security (Gómez, 2009), and primarily focuses on disease surveillance systems (Zimmerman and Smith, 2011). Sometimes its assistance extends beyond the region. There are examples of trilateral assistance that includes malaria control and prevention programmes in sub-Saharan Africa and training in Africa, the Middle East, and former Soviet republics (Tytel et al., 2012). Literature on Russia's influence on, and specific activities for, global health are scarce, and this was reflected in the dearth of information from in-country stakeholders.

Russia was only reported to have a presence in Chad and Tanzania. For example, *Physicians used to go to the Soviet Union for education* (TDOECDPartner2) but do not anymore. No respondents in Chad provided concrete examples of Russian engagement. *Russia has "diplomatic relationship" across all sectors. Russian projects are somewhat superficial and are clearly to increase visibility rather than to reach an objective* (TDMultilateral1). In Tanzania, only one respondent mentioned engagement with Russia. *Russia provides training at both the undergraduate and post-graduate levels. It sends two to three consultants to one or two tertiary care hospitals when we lack the required speciality* (TZConsultant2).

With so little insight, the only conclusion to draw is that Russia is not very active in the health sectors of the four case-study countries, but this is not surprising given its bilateral assistance priorities.

### *India*

Studies have shown that India uses a 'recipient driven' approach to development assistance for health, and it focuses on supporting local government and small non-governmental organizations (NGOs), health infrastructure (Yang et al., 2014), technical assistance (Florini et

al., 2012), capacity building, and training (India-Africa Forum, 2015). India's development assistance for health primarily goes to South Asian neighbors and Africa, but the nature of assistance might differ between the two regions due to foreign policy interests (Yang et al., 2014). In sub-Saharan Africa, India has been an important source of cheap, generic pharmaceuticals (Hafner and Popp, 2011). In 2015, New Delhi hosted the Third India-Africa Forum Summit where India committed US\$10 billion in lines of credit and grant assistance of US\$600 million for development in Africa (India-Africa Forum, 2015). US\$10 million of this is dedicated to the India-Africa Health Fund. At the fourth Africa-India Partnership Day of the African Development Bank Annual Meeting, the Finance Minister suggested that India's successes in public-private partnerships in power and transport would translate well in the health sector (AfDB, 2016).

In Chad, India is reportedly supporting a group of development projects under the title of "The Big Nine", one of which is in the health sector (TDCoordination1), but we could not find any evidence of this in discussions with other respondents or in the literature.

Multiple respondents in both Mozambique and Tanzania confirmed that Indian physicians conduct training and fill gaps themselves in the health sector. *India also provides some medical personnel, with skills that are not available in Tanzania* (TZMultilateral3 and 4). In Mozambique,

*India is very willing to help in many ways, such as: training of doctors, short-term and long-term, telemedicine, and usage of natural medicines. There are some language communication problems, and India provides no financial assistance, but rather assistance in kind. Fifty Indian doctors came, but it was difficult to retain them due to financial reasons. Some of them remained in Mozambique and opened a private practice* (MZGovernment1).

Similarly, India is best known in Tanzania for its elaborate referral system for tertiary care. Hundreds of patients per year are subsidized by the Tanzanian government and third parties (TZMultilateral3); fees for service are charged at local rates (TZGovernment1). This system is run in concert with telemedicine services, but as one respondent clarified, *these are services for upper quintiles in Tanzania. Where is the support for those in poverty?* (TZOECDPartner7). From these responses it is difficult to know whether Tanzania's referral system with India is purely medical tourism with affluent Tanzanians receiving treatment. It is also unclear whether these services are subsidized by the Tanzanian government.

In terms of pharmaceuticals, India is reported to be the largest supplier of generic medicines in sub-Saharan Africa (Hafner and Popp, 2011). In Tanzania, multiple respondents shared that India is an important partner for procuring essential medicines. As with all of India's support, it is *unclear if any of it is in the form of assistance, or if it is all paid for by Tanzania* (TZOECDPartner7 and 8). In Ghana, the relationship is clear. *India is mainly engaged in manufacturing and supply of pharmaceuticals. Indian companies cover 80% of imports of medicines and equipment in Ghana [with 64% of the market-share]* (GHMultilateral2). The India-Africa partnership for affordable medicines includes cheap, generic drugs as well as support for local manufacturing (UNAIDS, 2015), but it is still unclear whether these transactions are purely a response to an opening in the markets or if there are formalized agreements between the governments as part of foreign policy. India as a the largest source for medicines is also of particular interest in light of counterfeit manufacturing in India (Erhun et al., 2001, Harris, 2014).

Overall, India's activities in the case-study countries align with the literature, but for the most part, it is unclear how much of their engagement is sponsored by the Indian government, recipient government, or the patients themselves.

### **China**

Though China has played a significant role in regional discussions on public health preparedness and disease surveillance, health is not a priority in its foreign assistance programmes overall. Its primary foci are health infrastructure, human resources capacity building, provision of international medical teams, reproductive health and family planning, and malaria control (Tytel et al., 2012). Health assistance is used as a diplomatic tool to bolster its image abroad as well as secure access to natural resources (Bliss et al., 2010, Huang, 2010). Bilateral channels are the primary means of Chinese foreign health assistance with Africa as the principle target. The Forum on China-Africa Cooperation (FOCAC) serves to strengthen trade and development ties (FOCAC, 2016), and the framework includes malaria treatment and control programmes (Huang, 2010). Its projects are not currently integrated with other global malaria programmes; the Forum issues grants for antimalarials and support to malaria treatment facilities (Tytel et al., 2012). China has been sending medical teams abroad since the 1960s; these teams provide free medical care and train local medical staff in areas lacking access to health services (Huang, 2010, Government of China, 2006). In addition to on-site training programmes, China offers scholarships to health care personnel from low-income countries to



receive training in China. China is well-known for its role in infrastructure development, and this extends to the health sector. It has funded the construction of hospitals, clinics, and pharmaceutical manufacturing facilities, primarily in Africa (Bräutigam et al., 2011). It also provide funds for health commodities and medical equipment.

China has financed the construction of health infrastructure in all four case-study countries. To date, the facilities were reported to be in good working order, but some respondents expressed a lingering inner-conflict about the quality of Chinese investment. *One issue with BRICS cooperation will be efficiency versus sustainability. An example is the speed with which China can construct a hospital, but how long will it remain in good working condition. BUT China's vast resources are needed* (MZMultilateral1).

Mozambique and Tanzania both have long-standing relationships with China. Development partners in Mozambique were most concerned with sustainability because *[China is] not really concerned with overall Mozambican development* (MZOECDPartner4). While a government official viewed China's expediency and short-term focus in another light.

*It is very easy to submit requests and proposals, and we get quick responses. ... The short-term approach with China works well, because sometimes we need to forget the rules to get things done. Otherwise people will die. The assistance of the Chinese comes quickly, particularly when it is not financial but actually in terms of goods* (MZGovernment1).

This response mirror's other countries experience of Chinese development assistance as being 'recipient driven' (Yang et al., 2014), but this is in stark contrast to the accounts in Tanzania. *China provides loans not grants, and it sets the agenda. Conditions are economic conditions rather than governance and human rights conditions* (TZOECDPartner3). And in another discussion, *[the d]egree of fragmentation in South-South Cooperation depends on the agenda of the donor. For example, the Chinese intend to establish their own investment* (TZOECDPartner4, 5, 6). It is difficult to know if this difference in response is a product of different countries' relationships with China or if it is a difference in perspective (recipient government versus development partner). As it is, it can only serve to highlight lingering concerns about agenda-setting and the question about who the true recipient is- the government or the citizens it represents.

*China explicitly said that it is not interested in joining partner-led coordination. It is only interested in coordinating with the government* (TZOECDPartner4, 5, 6). Although China is not unique in its absence from country-level coordination efforts, an incident in Tanzania

illustrates stakeholders' concerns about emerging donors' lack of coordination. The *Chinese Premier came and signed 17 contracts with the Tanzanian government but the details of the content and nature were never disclosed. There was a large public outcry, but no subsequent response* (TZOECDDPartner7 and 8). Some see this trend as a concern for overall governance beyond development assistance for health.

In Ghana, China was the most visible BRICS country, but again it was in terms of investment and economic engagement rather than assistance; it has *provided Ghana with US\$3 billion across all sectors* (GHMultilateral6). In the health sector, China provides loans for the construction of hospitals and clinics (GHMultilateral2 and 6). It is best known in the health sector for the provision of health commodities, and one anecdote in particular sheds light on why respondents lack confidence in Chinese business practices.

*130 million counterfeit condoms were imported from China as part of a Global Fund grant. ... The origins of only 17% could be traced. They were shipped out of seven different Chinese ports. Nine separate shipments, totalling approximately 20 million condoms, made it through the Ghana Health Service, the Central Medical Stores and all the way down to the consumer. The orders arrived in Ghana in 2012 but were not identified as counterfeit until 2013* (GHMultilateral2).

The respondent went on to say that this also illustrates the inadequacy of post-procurement tracking in Ghana. This systemic weakness is of even greater concern to GHMultilateral2 as s/he believes that in five to ten years, the BRICS countries will be Ghana's largest partners in industry. *BRICS pose the biggest threats because of their poor business practices. There is no tracing to prevent fraud. Companies are also ignorant of international standards.* (GHMultilateral2).

This lack of transparency and accountability as experienced in Ghana and Tanzania make it difficult to monitor the influence and effectiveness of China as a partner.

### **South Africa**

Due to the high burden of HIV/AIDS and tuberculosis and the resultant strain on the domestic health system, South Africa must focus primarily on domestic priorities. Though South Africa receives more funds than it donates, it does contribute to foreign assistance for health through multilateral agencies, bilateral partnerships, and South-South cooperation. Its assistance is delivered mainly in the form of grants and technical support to other African countries. South Africa hosts a number of important research institutes and is a regional centre for research and development of medicines and vaccines for various infectious diseases. Generic drugs,

including first-line antiretrovirals (ARVs), are produced domestically (Tytel et al., 2012). Currently it does not play an influential role in the health sector in the four case-study countries.

In Chad, respondents acknowledge that South Africa is *important in the mobilization of the diaspora* (TDMultilateral1) and is *strengthening its economic ties with Chad through partnerships [as reflected by the increased number of flights]* (TDMultilateral1). But there has been no concrete evidence to suggest that South Africa will engage with the health sector.

Though South Africa is currently Mozambique's *number one training partner for Mozambique* (MZOECDpartner1), both Mozambique and Tanzania predicted that cooperation with South Africa will diminish in the coming years because it is now cheaper to send patients to India (MZGovernment1, TZMultilateral3 and 4).

Respondents in Mozambique and Tanzania suggested that South Africa's low visibility is because it is more involved in the private sector. In Tanzania, this highlighted the role of ideology in assistance. *South Africa's presence in Tanzania's health sector is very weak due to the different system typologies. Tanzania is predominantly focused on strengthening the public sector whereas South Africa emphasizes the private sector* (TZConsultant2). In general, interviewees were unfamiliar with activities in the private sector, so while this could not be confirmed, it is an interesting hypothesis about the how partnerships are forged in South-South cooperation.

Overall, the BRICS countries appear to be more engaged with the OECD's donor darlings, and each of the BRICS largely followed their set norms in development assistance for health (Table 18).

Table 18. BRICS support in case-study countries

	Chad	Ghana	Mozambique	Tanzania
<b>Brazil</b>			<ul style="list-style-type: none"> <li>• anti-retrovirals factory incl. technology (MZMultilateral3, MZGovernment1, MZOECDPartner1, MZMultilateral2, MZOECDPartner10).</li> <li>• investment in National Institutes of Health (MZGovernment1).</li> <li>• Milk Bank in Maputo (MZGovernment1).</li> <li>• MSc in Health Systems - Brazilian professors and accreditation of diplomas (partnership with FIOCRUZ; MZGovernment1).</li> <li>• training and technology for dentistry (MZGovernment1).</li> <li>• trilateral agreements with US (MZOECDPartner1, 7, 8, and 9).</li> <li>• physician training (MZOECDPartner1).</li> </ul>	<ul style="list-style-type: none"> <li>• physician training (TZOECDPartner4, 5, 6)</li> <li>• generic products (TZMultilateral6 and 7)</li> <li>• unspecified trilateral agreement with EU (TZAcademic2)</li> </ul>
<b>Russia</b>	<ul style="list-style-type: none"> <li>• “diplomatic relationship” across all sectors - projects superficial and clearly to increase visibility rather than to reach objective (TDMultilateral1)</li> </ul>			<ul style="list-style-type: none"> <li>• training - undergraduate and post-graduate (TZConsultant2)</li> <li>• 2-3 consultants to 1-2 tertiary care hospitals when lack required speciality (TZConsultant2)</li> </ul>
<b>India</b>	<ul style="list-style-type: none"> <li>• nine projects called the “Big 9”, including health sector (TDCoordination1).</li> </ul>		<ul style="list-style-type: none"> <li>• physicians (MZMultilateral2, MZGovernment1)</li> <li>• training, telemedicine, natural medicines (MZGovernment1)</li> </ul>	<ul style="list-style-type: none"> <li>• referrals, training, low-cost equipment, generic products (TZMultilateral6 and 7)</li> </ul>
<b>China</b>	<ul style="list-style-type: none"> <li>• mostly involved in economic activities, but overall is an important partner for Chad.</li> <li>• construction of some clinics and secondary care hospital in N’Djamena (TDMultilateral1, TDOECDPartner3 &amp; 4, TDMultilateral3 and 4)</li> </ul>	<ul style="list-style-type: none"> <li>• China is building hospitals in Ghana and provides training too. However, it is very “cautious”. It is difficult to obtain land for private investment (GHMultilateral2).</li> </ul>	<ul style="list-style-type: none"> <li>• antimalarials (MZMultilateral5, MZGovernment1)</li> <li>• physicians (MZMultilateral2, MZGovernment1)</li> <li>• medical equipment, accommodation for physicians near Maputo Central Hospital (MZGovernment1).</li> </ul>	<ul style="list-style-type: none"> <li>• medical teams (TZConsultant2, TZOECDPartner2, TZGovernment5, TZGovernment1, TZMultilateral6 and 7, TZMultilateral3 and 4)</li> <li>• supplies/equipment (TZConsultant2, TZGovernment1)</li> <li>• subsidized medical training in China (TZConsultant2, TZOECDPartner7 and 8)</li> </ul>
<b>South Africa</b>			<ul style="list-style-type: none"> <li>• South Africa is involved, as part of a regional system, in the procurement of medicines. It supports enterprises through public-private partnerships (MZOECDPartner5).</li> <li>• We have a bilateral cooperation agreement for tertiary referral with South Africa in the context of SADC (MZGovernment1).</li> </ul>	<ul style="list-style-type: none"> <li>• Subsidize training (TZMultilateral3 and 4)</li> <li>• Equipment (TZMultilateral1 and 2)</li> </ul>

### *Non-BRICS emerging economies*

Although respondents reported having very little exposure to BRICS in the health sector, they often spontaneously mentioned other so-called emerging economies. After this happened in a few interviews, we altered our questions to include “BRICS and other emerging economies”. Each case-study country had a distinct set of emerging economies that contribute, or have made pledges, to the health sector (Figure 14) (Annex 2 for details of engagement).

	Colombia	Cuba	Egypt	Iran	IDB	Israel	Japan*	Malaysia	Mexico	Saudi Arabia	S. Korea**	Turkey
Chad												
Ghana												
Mozambique												
Tanzania												

*Figure 14. Non-BRICS emerging economies engaged with case-study countries*

IDB : Islamic Development Bank ; \*Japan has been a member of the OECD DAC since 1961 (OECD, 2016a) ; \*\*South Korea has been a member of the OECD DAC since 2010 (OECD, 2016b)

Currently there is no data on these non-BRICS emerging economies’ health-specific development assistance, and these countries have not had high profile participation in international discussions. Recent annual gross domestic product (GDP) growth has slowed for the BRICS countries, decreasing their distinction from other emerging economies (Figure 15). At the country-level, these non-BRICS emerging economies also lack visibility, in part due to their absence from coordination groups. This is not unique to these four recipients or their respective donors (Kragelund, 2008).

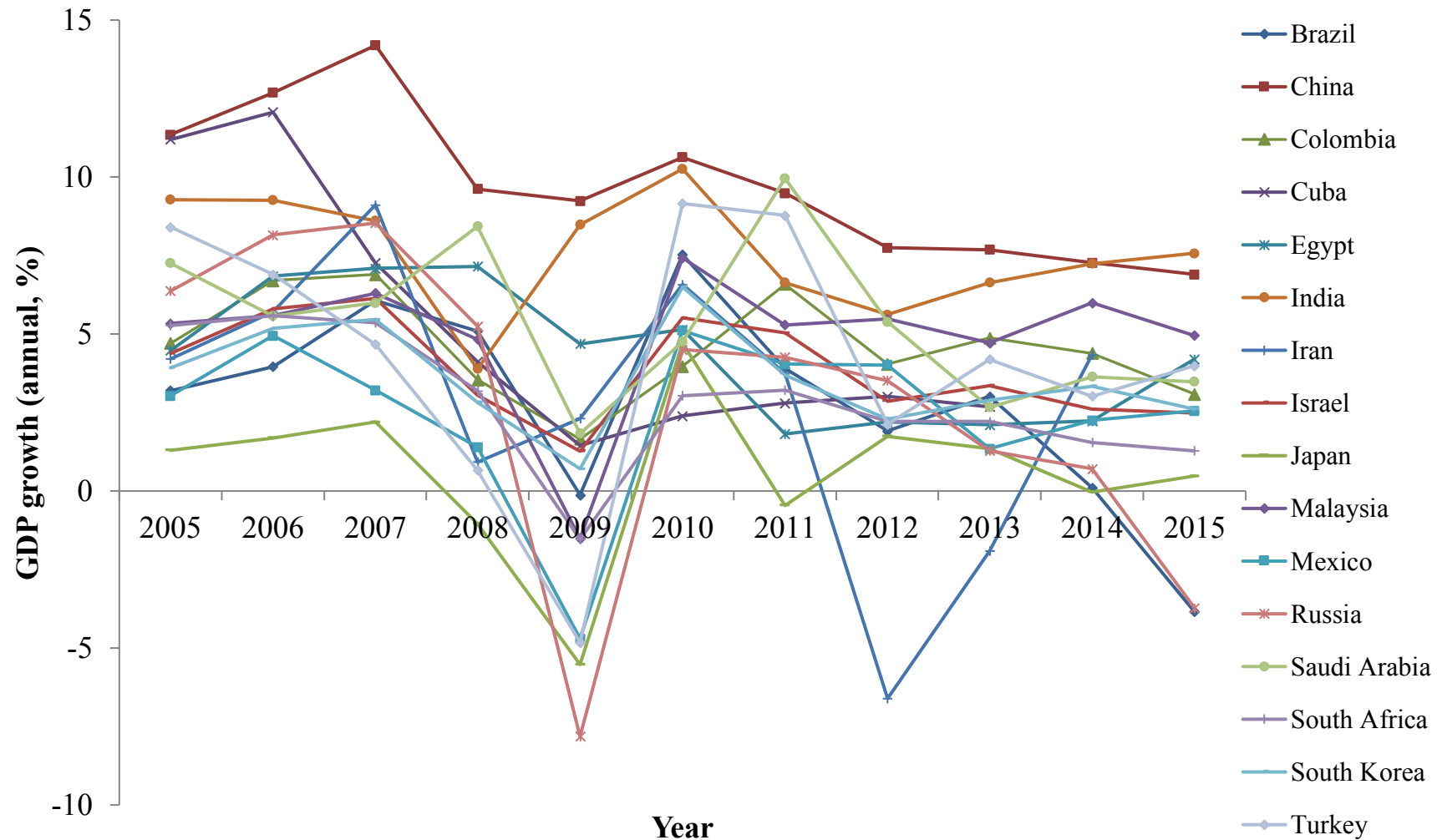


Figure 15. GDP growth (annual, %), emerging economies active in case-study countries  
World Bank national accounts data, and OECD National Accounts data files (The World Bank, 2016)

When asked about the engagement of the BRICS and emerging donors in the health sector, a number of interviewees in Ghana and Tanzania included Japan and South Korea. Respondents in Mozambique mentioned South Korea. This is surprising in that Japan has been a member of the OECD DAC since 1961 (OECD, 2016a). South Korea has been a member of the OECD DAC since 2010 (OECD, 2016b). Japan's development assistance for health in Tanzania has been steady at approximately US\$3-4 million per year. Its support for Ghana it increased dramatically from US\$3.2 million in 2010 to US\$7.7 million in 2011 and again to US\$18.8 million in 2012 (OECD, 2016g).

Development assistance for health from South Korea has been growing in all four countries, but Mozambique and Tanzania have seen the most dramatic increases. Mozambique received US\$17 thousand in 2012 and US\$16.3 million in 2013. Likewise Tanzania received US\$2.7 million in 2012 and US\$16.3 million in 2013. Ghana's growth in support has been much slower and in 2013 still only received US\$2.5 million (OECD, 2016g).

These dramatic increases in development assistance for health coincided with the interviews and could explain, in part, why these long-time donors were grouped with emerging donors. One respondent in Ghana provided a hypothesis as to *why* Japan and South Korea were increasing their assistance.

*Currently the predominant bilateral players in health are [the United Kingdom], the [European Union], the Netherlands, Germany, Japan, and South Korea. South Korea even employs health advisors in their embassies. I predict that Japan, and possibly South Korea, will replace conventional donors especially in light of their political concern of the increasing presence of China in sub-Saharan Africa (GHMultilateral2).*

This is a remarkable hypothesis about the influence of shifting geopolitical interests that merits further exploration.

## 5.5 Conclusions

Overall, based on all of the interviews, BRICS do not contribute significantly to the public health sector. Interviewees see space for them in the landscape but acknowledge that myriad obstacles exist. They are not seen as a replacement, but rather as a supplement, for conventional aid. They are not foreseen to provide assistance that resembles conventional aid; they are primarily focused on investment opportunities.

Though the BRICS have a more public profile in international development than other emerging economies, there are many other emerging economies acting in-country. These donors also have limited visibility within the network of development partners, and presumably the strengths and challenges ascribed to working partnering with the BRICS extend to these other emerging economies.

These actors all reportedly interact directly with the government, but they are not participating in donor coordination bodies. In order to prevent further fragmentation, emerging donors should be informed of, and included in, development partner group discussions.

## 5.6 Take-home messages

- The BRICS countries are not the only emerging economies acting in the health sector of sub-Saharan African countries.
- Emerging economies are not seen as a replacement, but rather as a supplement, for conventional aid. They are primarily focused on investment opportunities.
- Due to emerging economies lack of coordination, health development partners in-country are not well-informed of health-specific engagement.
- Some government officials welcome this unconventional engagement while development partners can be sceptical of the sustainability and long-term social welfare.

## 5.7 Acknowledgements

The authors would like to thank all participants for their time and interest in responding to interviews and follow-up. The authors would also like to thank our gracious hosts for their support in Chad, Ghana, and Tanzania, respectively: Dr Daugla Doumagoum Moto (Centre de Support en Santé Internationale; N'Djamena, Chad), Dr. Moses Aikins (University of Ghana; Accra, Ghana), and Dr. Honorati Masanja (Ifakara Health Institute; Dar es Salaam, Tanzania). Additionally, we would like to thank Dr. Charles Mayombana for being such a helpful guide in the halls of the Ministry of Health and the streets of Dar es Salaam and Malaba Haroun for patiently translating interviews in N'Djamena. This work was funded by the Swiss Network for International Studies (reference # 3938) and the Swiss Tropical and Public Health Institute.



## 6. The Global Fund's paradigm of oversight, monitoring, and results in Mozambique

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Submitted to **Globalization and Health**

## 6.1 Abstract

The Global Fund is one of the largest actors in global health. In 2015 the Global Fund was credited with disbursing close to ten percent of all development assistance for health. In 2011 it began a reform process in response to internal reviews following allegations of recipients' misuse of funds. Reforms have focused on grant application processes thus far while the core structures and paradigm have remained intact. We report results of discussions with key stakeholders on the Global Fund, its paradigm of oversight, monitoring, and results in Mozambique. We conducted 38 semi-structured in-depth interviews in Maputo, Mozambique and members of the Global Fund Board and Secretariat in Switzerland. In-country stakeholders were representatives from Global Fund country structures (eg. Principle Recipient), the Ministry of Health, health or development attachés bilateral and multilateral agencies, consultants, and the NGO coordinating body. Thematic coding revealed concerns about the combination of weak country oversight with stringent and cumbersome requirements for monitoring and evaluation linked to performance-based financing. Analysis revealed that despite the changes associated with the New Funding Model, respondents in both Maputo and Geneva firmly believe challenges remain in Global Fund's structure and paradigm. The lack of a country office has many negative downstream effects including reliance on in-country partners and ineffective coordination. Due to weak managerial and absorptive capacity, more oversight is required than is afforded by country team visits. In-country partners provide much needed support for Global Fund recipients, but roles, responsibilities, and accountability must be clearly defined for a successful long-term partnership. Furthermore, decision-makers in Geneva recognize in-country coordination as vital to successful implementation, and partners welcome increased Global Fund engagement. To date, there are no institutional requirements for formalized coordination, and the Global Fund has no consistent representation in Mozambique's in-country coordination groups. The Global Fund should adapt grant implementation and monitoring procedures to the specific local realities that would be illuminated by more formalized coordination.

### Key words

Global Fund ; Mozambique ; financial management ; performance-based finance ; coordination ; country oversight ; reform ; New Funding Model

## 6.2 Introduction

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) is a financial instrument established in early 2002 (Sherry et al., 2009). Its formation was part of the “emergency response to accelerate the scale-up of control of the major communicable diseases, especially HIV/AIDS” in light of the Millennium Development Goals (MDGs) (Biesma et al., 2009). Governments provide approximately 95% of Global Fund support; the private sector provides the rest (The Global Fund, 2016o). Since its inception, it has disbursed more than US\$30.6 billion (The Global Fund, 2016a). In 2015, the Global Fund was the world’s largest channel of finance for malaria and tuberculosis (40% and 49% of total support, respectively), and the second largest channel for HIV/AIDS (16% of total support). In terms of overall contribution, the Global Fund was responsible for nine percent of funding for global health in 2015; it reached its maximum in 2012 and 2013 when it oversaw the disbursement of 12% of the total funds dedicated to development assistance for health (IHME, 2016).

The Global Fund has seven core structures, the: Board, Office of the Inspector General, Technical Review Panel, Principle Recipient, Country Coordinating Mechanism, Staff / Secretariat, and Local Fund Agent (The Global Fund, 2016n). The Global Fund Board is the overall governing body responsible for defining policies, objectives, and strategies. It includes representatives from both donor and recipient countries, non-governmental organizations (NGOs), the private sector, and affected communities (The Global Fund, 2014). The Office of the Inspector General (OIG) is an independent body that oversees investment effectiveness including risks associated with misused funds. The Technical Review Panel (TRP) is an independent team of health and development experts that evaluates proposals submitted to the Global Fund (The Global Fund, 2016l).

The Principle Recipient (PR) is responsible for grant implementation and can either be part of the public sector, e.g. a ministry, an NGO, or even a private company. The PR is under the direct supervision of the Country Coordinating Mechanism (CCM). The CCM is reflective of the Global Fund’s dedication to local ownership and decision-making. It writes the original grant proposal, nominates implementers, and governs grant implementation. The CCM is a partnership of country stakeholders including the private sector, academic institutions, multilateral and bilateral development partners, civil society, and key affected populations (The Global Fund, 2016l).

The Global Fund Secretariat is responsible for the daily operations, primarily grant management. The Secretariat engages with Principal Recipients through country teams. The Global Fund does not have offices in recipient countries. Instead it uses Local Fund Agents (LFAs) to oversee grant management (The Global Fund, 2016l).

In October 2010 the Global Fund received its largest replenishment, to date, at US\$11.7 billion despite allegations of illicit use of funds in Zambia, the Philippines, and Mauritania and subsequent freezing of their cash disbursements (The Global Fund, 2010a, The Global Fund, 2010b, The Global Fund, 2009b, The Global Fund, 2009a). At the 22<sup>nd</sup> Board Meeting, the OIG released its Progress Report for March through October 2010. It outlined its findings from investigations of allegations of fraud, corruption, and misuse of funds in seven countries (The Global Fund - OIG, 2010). On 23 January 2011, the Associated Press published a story, “Fraud Plagues Global Health Fund” (Heilprin, 2011). More than 250 media outlets worldwide covered the story and within days Germany froze its contribution to the Global Fund (Rivers, 2011). Over the coming months the Global Fund underwent independent review, re-visited its 5-year strategy, and committed to urgent reform (The Global Fund, 2011c, The Global Fund, 2011b, The Global Fund, 2011a). Within one year, its Executive Director, Michel Kazatchkine, announced that he would step down, cutting his tenure two years short (The Global Fund, 2011c, The Global Fund, 2012a). Gabriel Jaramillo, former Chairman and Chief Executive Officer of Sovereign Bank, was appointed as General Manager to oversee the transformation plan (The Global Fund, 2012b). Mr. Jaramillo lacked technical expertise in health development, but he specialized in managing change in complex financial institutions during his 36 years of experience in banking in Latin and South America and the US (Harvard T.H. Chan School of Public Health, 2014).

The OIG systematically audited recipients and identified US\$118 million in losses as of 19 September 2013 (Garmaise, 2013). It is important to note that these losses are only 0.5% of the US\$22.7 billion that the Global Fund had disbursed worldwide at the time (The Global Fund, 2016d). Overall, the Global Fund has a particularly high level of financial accountability, compared with other global health agencies, and is diligent in its response to these relatively small abuses.

### *The New Funding Model*

Reforms resulted in what became known as the New Funding Model (NFM). It has five key characteristics: flexible timeline, simplified grant application processes, shorter approval

processes, enhanced engagement of all partners prior to grant submission, and improved predictability of funding (The Global Fund, 2016b). In short, the reform focuses on processes, not structure or paradigm.

Initially the Global Fund application process was in distinct rounds announced by a call for proposals approximately three months before a submission deadline. In the NFM, funding cycles are flexible and countries can submit a so-called concept note any time during windows. This allows countries to align the grant timeline with national fiscal years and strategies. Countries are eligible to apply for a pre-assigned amount per disease, called “the envelope”. Envelopes are determined by countries’ burden of disease and ability to finance. This approach is meant to enhance predictability of funding (The Global Fund, 2016b).

CCMs seek technical assistance to write grants for the three diseases (and health systems strengthening (HSS) which can either stand alone or be incorporated into a disease-oriented grant). Upon submission, grants are screened for eligibility by the Secretariat and then passed along to the TRP which recommends technically sound proposals for funding. The Board gives official approval of chosen grants. The grants undergo classifications and budget cuts by the Board before being returned to the TRP for negotiations, further reductions of the budgets through efficiency gains, and division between multiple PRs (and the subsequent necessary modifications to the budget). Then PRs and the Global Fund sign the final grant agreement. The most notable change in the NFM is that from the beginning, country teams are engaged in country-level dialog on concept note development (Figure 16).

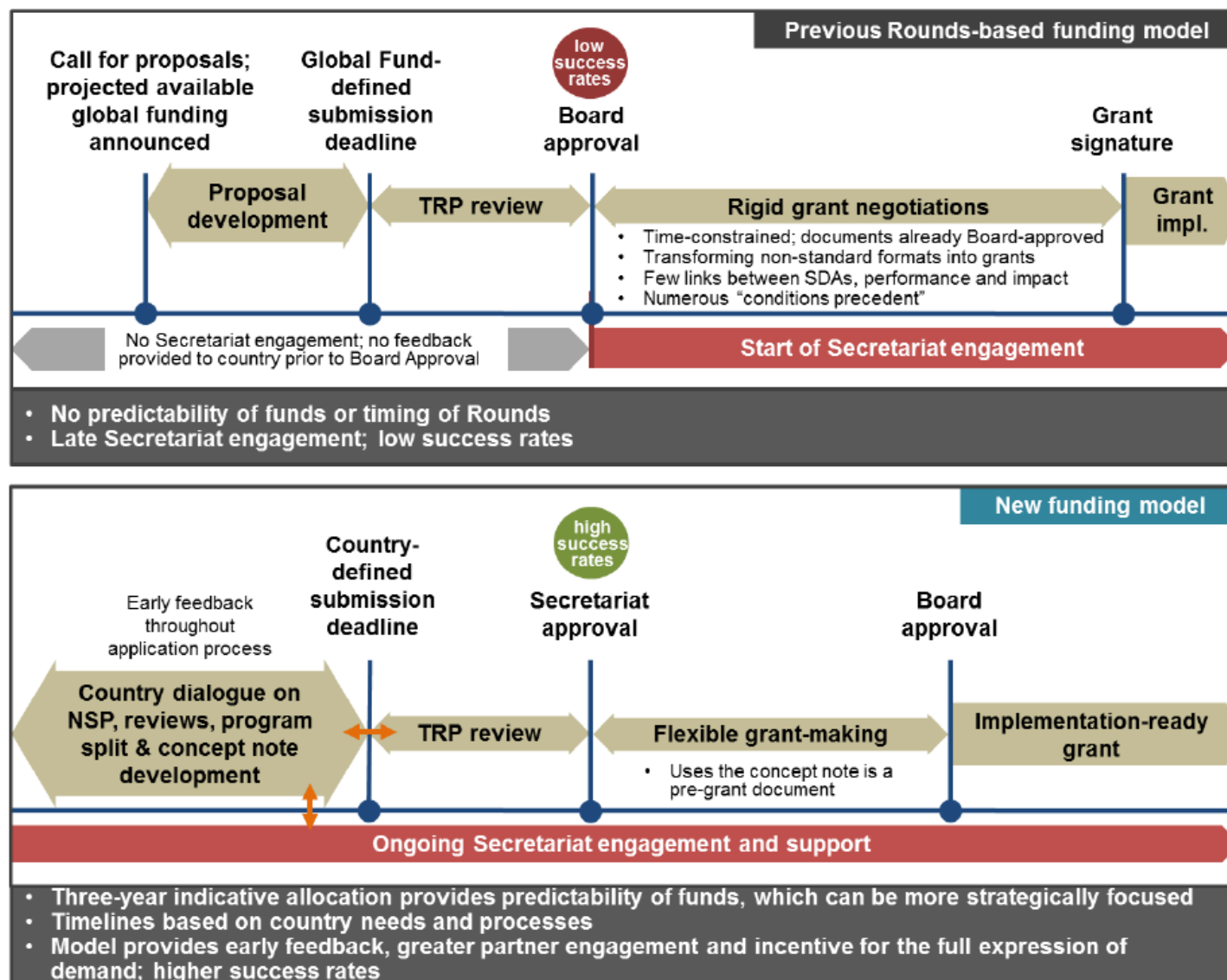


Figure 16. Comparison of the Rounds-based funding process and the New Funding Model  
(The Global Fund, 2013b)

### *The Global Fund in Mozambique*

As of 2016, Mozambique has been awarded 17 grants. The Global Fund signed, committed, and disbursed a total of more than US\$972 million, US\$802 million, and US\$620 million, respectively, to Mozambique in its fight against the three diseases. (Please note that the discrepancy between values of signed, committed, and disbursed is due to active grants.) The average portfolio is US\$466 million making Mozambique the 12<sup>th</sup> highest recipient of Global Fund support (The Global Fund, 2016o).

Of Mozambique's 17 grants, 12 have been awarded to the Ministry of Health, representing 86% of funds disbursed to Mozambique. From 2004 and 2008 the Global Fund disbursed US\$135.8m into a health financing basket, known as PROSAUDE (The Global Fund - OIG, 2012).

In early grants, scorecards issued at the end of Phase I often reported “weak financial management practices and capabilities within the MOH resulting in weak financial accountability for resources used” along with difficulties tracking funds PROSAUDE (The Global Fund, 2016g, The Global Fund, 2016h, The Global Fund, 2016i, The Global Fund, 2016j, The Global Fund, 2016k). In 2011, in response to calls for increased accountability, the OIG began an audit of Global Fund grants to Mozambique's Ministry of Health for years 2008, 2009, and 2010 (The Global Fund - OIG, 2012). Five months into the audit they concluded a total of US\$3,318,395 was inadequately accounted for. The OIG recommended that the Ministry of Health repay the PROSAUDE. Overall, they concluded that there were not “adequate controls ... in place to manage the key risks impacting the Global Fund supported programs” (The Global Fund - OIG, 2012).

This study was conducted to understand how the Global Fund was experienced by key stakeholders in Maputo, Mozambique and how recent reforms were experienced by key stakeholders in Mozambique as well as by Global Fund stakeholders in Geneva, Switzerland. In late 2013 members of the research team conducted interviews with 38 representatives from these two groups.

## **6.3 Methods**

### *Primary data collection*

Data was collected as part of a larger study on the influence of emerging donors in health development (SNIS, 2012). For the purpose of the larger study “emerging donors” includes public-private partnerships, philanthropic foundations, corporate social responsibility

programmes, Brazil, Russia, India, China, South Africa (the BRICS), and other emerging economies. The investigators conducted 37 face-to-face and one phone-based semi-structured in-depth interviews with stakeholders in Maputo, Mozambique and members of the Global Fund Board and Secretariat in Switzerland. In-country stakeholders were representatives from Global Fund country structures (eg. Principle Recipient), the Ministry of Health, health or development attachés of partner embassies in-country, selected UN agencies, consultants, and the NGO coordinating body (Table 19). Interviews were held in the offices of key informants in Switzerland and Maputo, Mozambique. Interviews lasted approximately one hour but ranged from 45 minutes to three hours.

*Table 19. Interviewees by representation*

<b>Representation</b>	<b>Number of Interviewees</b>	<b>Nomenclature in paper</b>
Global Fund Board	5	GFBoard#
Global Fund Secretariat	5	GFSecretariat#
Global Fund Country Structure*	4	GFCountryStructure#
Academia	1	Academia#
Consultant Firm	2	Consultant#
Non-governmental organization	3	NGO#
Multilateral Agency	6	Multilateral#
OECD Partner	10	OECDPartner#
Coordination Body	2	Coordination#
<b>Total</b>	<b>38</b>	

\*includes Local Fund Agents, Country Coordinating Mechanism, Principal Recipients, and Sub-Recipients; members of the CCM may be a representative of a multilateral agency or OECD Partner (Organization for Economic Cooperation and Development).

# refers to interviewees in chronological order

Investigators contacted prospective interviewees via email. We obtained email addresses through professional contacts and official websites. Emails contained a brief description of the research team, overall research questions and objectives, and methods. Respondents suggested additional interviewee(s) who were then contacted directly by the research team.

Interviewers used a semi-structured interview guide (see Annex 1). Discussions included questions about interviewees' perspectives on overall changes in development assistance for health and resulting influences at country-level. Interviewees were also asked to share their opinions about who they perceived to be the most influential private sources of finance including the Global Fund. Many of interviewers' questions were in the context of the Global Fund as an international non-governmental organization as opposed to an intergovernmental organization or a purely bilateral donor. We asked open-ended questions about Global Fund engagement with the government and other donors. Interviewers allowed respondents to lead



discussion for the most part and followed up with more detailed questions for clarification. Interviewers also asked questions based on insights provided in earlier interviews.

The majority of interviews conducted in Switzerland followed a similar structure to those in Mozambique. Five interviews were conducted much later, in mid-2015, after an initial content analysis, and focused on the Global Fund and the New Funding Model, specifically (Academic1, NGO1, GFCountryStructure1, GFBoard4 and 5, and GFSecretariat5).

In Mozambique 23 interviews were conducted. The discussions were primarily in English with periodic clarifications in Portuguese as one investigator speaks Portuguese fluently. In Switzerland, 11 interviews were conducted with 13 interviewees. All discussions were in English. One phone-based interview was conducted in English, and a second member of the in-country NGO coordination body provided input via email in response to later follow-up.

Key informants in Mozambique received follow-up questions nine months after the initial interview. Of the 24 interviewees, eleven responded and two referred the investigators to new respondents who provided input.

### *Analysis*

The corresponding author combined interviewers' notes into one Microsoft Word document per interviewee and organized the material into fundamental themes- type of donor, aid management, health system, country context, etc. The corresponding author uploaded interview notes into MAXQDA 11 (UdoKuckartz; Berlin, Germany) and read each at least three times. Each successive reading was accompanied by descriptive, analytic, and thematic coding, respectively, to assemble discussion points on the Global Fund paradigm and country-level engagement. The interview notes were indexed using the framework and included sub-themes as determined by the initial analytic coding (Gale et al., 2013).

To maintain respondents' anonymity, each interviewee was given a label with the following nomenclature: two letter country code, professional affiliation, and number (based on chronological order of interviews of people with same professional affiliation). For example, "OECDPartner2" for the second OECD Partner interviewed.

## **6.4 Results and Discussion**

### *History of the Global Fund in Mozambique*

Mozambique first received Global Fund support in Round 2 (year 2004) for all three diseases. The Global Fund signed Mozambique's first Memorandum of Understanding (MoU) for the sector-wide approach, the PROSAUDE. It channelled resources through the basket until the audit of Round 7. Due to problems with reporting and tracing expenditure, the Global Fund paused funding for Round 8 (year 2008). Meanwhile the second PROSAUDE MoU was released; the Global Fund did not sign.

The Round 8 grant expired while awaiting results of the OIG's Round 7 audit. Continued support during the audit would have required a parallel system for operation. Interviewees gave different accounts of the audit. Those who work closely with the Global Fund described it very matter-of-factly. To paraphrase: It was initially claimed that US\$14 million was unaccounted for, but after one year, the audit deemed US\$1 million missing. This is not surprising given the nature of pooled funding. Eventually the government repaid the US\$1 million (OECDPartner1). But one interviewee from a bilateral agency was more cutting in response,

*In standard auditing protocol, the organization would be given three months to provide proper evidence for spending. The Global Fund gave three months, three times. ... This is not good practice. The Global Fund hid behind its procedures. They did not grant access to their draft reports even though they audited bilateral funding by nature of auditing pooled funding. This is not a healthy approach. They are not improving health or a health sector when covering up results this way (OECDPartner10).*

Three years after the audit, the Round 8 HSS grant was re-constituted in June 2012. The Ministry of Health is the principle recipient, and the grant focuses on risk mitigation and reporting as per the OIG's report. Despite the Global Fund reforms in application processes, *[the grant proposal] went through the old bureaucratic processes (OECDPartner1).*

In Mozambique the audit, requirements for financial management, and performance-based approach, have inspired questions about Global Fund's paradigm given the contexts in which it works. One quote in particular encapsulates many of the concerns addressed piece-meal in other interviews.

*The Global Fund has two choices: either continue to not have people on the ground or relax their requirements for monitoring and evaluation. As it stands there is no one on the ground, they maintain their high expectations, and have other partners doing*

*their monitoring for them* (OECDPartner2).

Respondents in both Mozambique and Switzerland voiced concerns about the combination of weak country presence/oversight/guidance with stringent and cumbersome requirements for monitoring and evaluation (M&E) linked to performance-based financing. They felt this combination forces buttressing by partners. Respondents in Geneva also expressed concern that perceived weaknesses of partners add risk in this paradigm.

### *The Global Fund paradigm*

The Global Fund highly values recipient ownership in program development, implementation, and evaluation (Atun and Kazatchkine, 2009). The PR leads grant application, administers funds, develops their targets for performance-based funding, and tracks results (The Global Fund, 2016f). Due to this emphasis on country ownership, the Global Fund operates without country offices (The Global Fund, 2016m). Communication with the Global Fund is entirely dependent on country teams. Often the PR seeks technical assistance, particularly for grant application and evaluating performance (The Global Fund, 2016s). Additionally recipients are typically supported, to some degree, by development partners on the ground (The Global Fund, 2016r). Bilateral agencies working in the country provide support, some more than others, because they also have vested interest in Global Fund's success as they are donors to the Global Fund.

Each country in the larger four-country study on emerging donors for health had a different experience and relationship with the Global Fund, but the general tone of response in Mozambique was that of a question- does the current approach of the Global Fund fit with country-level needs? Most interviewees were active before, during, and after the audit and were left with concerns about the future of the Global Fund in Mozambique as it undergoes its first phase of reform. *Global Fund wants to follow only its own rules, and here it is not working* (Multilateral3). Perhaps the Global Fund's inflexibility to recipient needs is because it *tends to be obsessed with financial technicalities* (Multilateral2).

The Global Fund is a financier, rather than an implementing/development agency. Along with other global health initiatives created in the early 2000s, it was designed to overcome market and public failures in international public health, as well as disperse the power of the UN and its agencies (Buse and Walt, 2000). It was meant to offer streamlined, less bureaucratic, processes. Respondents in Mozambique suggested that the Global Fund currently functions somewhere between its predecessors and the vision of its creators.

*The Global Fund has straddled between a managerial and a bureaucratic model in Mozambique. They try to apply performance-based financing, but their grant management processes have been highly bureaucratic. They function as a bureaucracy, but they'd like to have performance-based targets (OECDPartner1).*

The cost of the bureaucracy extends beyond cumbersome administrative processes ... [s]o much money spent on managing and getting through the bureaucratic requirements of the Global Fund (OECDPartner1).

Despite respondents' concerns, they were hopeful about prospective changes with the New Funding Model, and more importantly about the capacity of the Global Fund to reform at all. *The Global Fund's New Funding Model addresses inefficiency concerns, and the recent changes in the Global Fund have shown how international organizations are capable of re-inventing themselves (GFCountryStructure2).*

The Global Fund's reform is unique for a large-scale organization (Hanrieder, 2016, Kelland, 2016), and respondents seemed to be providing constructive criticism with the hope that feedback would result in further reform of the Global Fund.

#### *Performance-based funding*

Results-based financing is an attempt to link financial input to health-related outcomes. Development partners compare the results of the funded project or program to pre-determined targets for a set of indicators. Although this approach is not new, there is a broader range of actors using a wider range of results-based models. If implemented properly, results-based finance can: align donor and recipient objectives, improve data reliability, give recipients a stake in the outcome of their efforts, and give recipients greater discretion and authority to carry out their tasks (Savedoff, 2010). On the other hand there are concerns about the effectiveness of these tools for health development (Oxman and Fretheim, 2009) and the feasibility of measuring outcomes of complex, system-level interventions (Meessen et al., 2011, de Savigny and Adam, 2009). To date, studies have focused on approaches that focus on paying for the results achieved by individuals or institutions (for example, health facilities or central medical stores). There has only been one study on results-based approaches to grant management (Fan et al., 2013).

Performance-based finance (PBF) is one of the guiding principles of the Global Fund; continued support for recipients depends on proven results. Their strategy to “actively manage grants based on impact, value for money and risk” includes increased emphasis on impact of funding,

investment in data systems, requirement of increased financial management transparency, coordination with recipients and other donors, and avoidance of duplicated or inconsistent demands on recipients (The Global Fund, 2012c).

GFSecretariat2 shared that the organization uses a more progressive model of PBF than a strictly results-based approach. Currently the approach centers upon progress and improved performance of national programs. They focus on country ownership of results and corrective actions. The Global Fund wants to understand why a country is not performing, not just where the money is going. *Part of this decision-making is to get countries themselves to do their own performance reviews. So part of it is not just the mechanical rating, it's that they actually do review their results against their targets, and they explain the deviations and they come to an overall rating* (GFSecretariat2).

While this approach is arguably more holistic, it has been reasoned that the subjective elements of their evaluation decrease incentives to improve performance (Fan et al., 2013). This conclusion was supported by a development partner in Mozambique. *The recipients' criterion for success is disbursement rather than results* (OECDPartner10).

The Global Fund approach was described as a streamlined skeleton which countries built upon to create their own performance evaluation. *...we had several hundred indicators and we've reduced it down to a top set of 10, which are highly weighted, but then a country can use further indicators. They have to set targets, and then it's really how many of those targets are reached* (GFSecretariat2). But concerns at the country-level focus on burdens placed on data collection systems. *There is an enormous amount of paperwork to fill out ... All data that is not aggregated in the routine national health information system must be gathered in the programme* (GFCountryStructure4). Multilateral3 shared that Mozambique has performed well and accomplished targets despite the obstacles posed by Global Fund requirements. They have achieved results although *[i]t is difficult to comply with the requirements (in terms of prescribed health indicators) ... Reporting has not aligned with the health information systems. There has been a duplication of efforts from the ground all the way to central level.*

Overall, there appears to be a strong association in the minds of respondents in Mozambique between performance-based funding, financial tracking, and the audit. This results in distaste for the approach. *There have been a lot of discussions about Global Fund's inflexibility and unrealistic demands of a developing country. 'You are asking for oranges, but we only have bananas'* (OECDPartner1). Some respondents were more hopeful that distance from the audit

will change the relationship with the Global Fund. *The Global Fund has a horrendous story with performance-based financing. There have been improvements in the past two years* (OECDPartner2). Both of these quotes illustrate a disconnect between the perception of PBF at headquarter-level and at the country-level. In Geneva they believe this approach will ultimately help countries identify obstacles to meeting national goals and incentivize problem-solving. In Mozambique this approach feels based on implausible expectations and a resulting frustration.

Mozambique does not necessarily have the financial management capacity required to satisfy Global Fund demands, and this directly affects return-on-investment measurements. Additionally, addressing the obstacles identified in the performance evaluation would require systems support.

*They give more money than such a weak system can properly absorb. So overall they might be doing more harm than good. Giving such a large sum of money without the proper checks and balances leads to corruption and growing inequality* (OECDPartner10).

Mozambique is not alone in this. Low absorption capacity has been blamed for the failure of many development assistance projects in African countries. Donor agencies complain that insufficient physical infrastructure and technical expertise at the local level generate high transaction costs and, thus, inefficiency in project implementation. *Distribution and institutional channels in Mozambique are weak and thus the US government takes a hegemonic approach* (GFCountryStructure2). Although many projects now include training modules to train technical experts and some funds for infrastructure needs, the managerial needs of aid administration and implementation are often overlooked. This leads, among others, to slow delivery of assistance and reporting problems (Austin, 1990, Easterly, 2013, Coase, 1937, Simon, 1947).

The Global Fund has targeted funding for health systems strengthening to build capacity among ministry officials for strategic planning and reporting tasks. Whether these efforts will succeed in creating the necessary institutional capacity to administer large-scale projects, remains an open question. *Their approach to health systems strengthening in lower-middle income economies has focused results coupled with a very weak country presence* (OECDPartner10). Multilateral<sup>3</sup> commented that this problem may be overcome in the capital, Maputo, as it has been in other parts of the world, but that given Mozambique's size and national reality, the issue needs to be addressed at provincial level.

Based on the interviews in Mozambique, it is difficult to know if the intention of the Global Fund's PBF has been communicated on the ground, or if it's been overshadowed by the administrative burden placed on the principle recipient. A Geneva-based interviewee made a small comment that implies, to date, headquarters has recognized the need for change. *[We need to] push down the performance-based funding so that it's not just done in a committee room in Geneva, but there are these program reviews that are done within countries, ... we need to invest much more that there's a process in-country, and performance-based at the country level* (GFSecretariat2). Until countries take full ownership of this process and are empowered by the intended purpose of performance-based financing, PBF will likely continue to be perceived as an administrative burden and identified as a siloed donor demand.

### *Country oversight*

The Global Fund does not have country offices. Instead they rely on country teams that are based in Geneva, travel to the country, and are led by a Fund Portfolio Manager. The team is comprised of programme officers, and legal, procurement, finance, and M&E staff (Garmaise, 2010). Team members are responsible for multiple countries. The number of countries varies by role, for example, the Fund Portfolio Manager is responsible for one or two countries whereas the Procurement and Supply Management Officers are responsible for up to five countries (GFCountryStructure1). Previously country teams typically visited Mozambique once annually, but with the changes under the New Funding Model, teams visit countries multiple times per year (Multilateral4; OECDPartner2). This increase in frequency has yielded mixed reviews. Many respondents saw it as an improvement because the country teams are becoming more familiar with the realities on the ground and are available for guidance. One respondent contradicted this feedback. *Countries also complain that country teams come too often. There is not enough time to make progress between visits, they are constantly working for the next visit, and this increases the time stress* (GFSecretariat5). Overall, the major concerns voiced by respondents were that country teams are over-worked and are therefore sometimes unsuccessful as the channel for communication, too much depends on an individual (the Fund Portfolio Manager), and the country teams are out of touch with the realities on the ground.

Aside from technical support for proposal development and grant implementation, country teams act as the primary channel of communication with Global Fund headquarters. *The Global Fund does not put things on their website to communicate widely with stakeholders, including at the country level. They rely on Fund Portfolio Managers and people on the country team* (NGO1). Interviewees in-country and in Geneva expressed concern about the reliance on

country teams. *The availability of expertise within the team is country-dependent. ... Personnel are over-worked and over-extended and as a result it is not uncommon for them to take extended leave. This has caused detrimental gaps in communication* (GFCountryStructure1).

The Global Fund has recognized some of the issues associated with the burden placed on country teams and *has begun to bring in technical expertise to help* (GFSecretariat5).

Overall, interviewees in Mozambique and Geneva agreed there are problems associated with the current paradigm of country oversight. *The Global Fund has weak country presence. Much more oversight is required; they must do more than disburse funds* (OECDPartner10). *Something that is missing in the Global Fund's current approach is close contact with the realities on the ground. There is also a high level of internal movement that affects continuity* (GFBoard4). GFBoard4 commented, *[e]mployees need a strong financial background rather than focusing on a background in development or field experience*. This was linked to the discussion about the Global Fund's quickness to remind that "we are a funder, not a development agency." This contributes to the perception the Multilateral2 voiced, *Global Fund tends to be obsessed with financial technicalities*.

As referenced earlier, one respondent believes that Mozambique's problems with grant implementation are a result of the lack of oversight combined with the expectations associated with performance-based financing. The Global Fund must either relax their M&E requirements or place staff in-country. As it stands they have other partners doing the monitoring required to meet their high expectations (OECDPartner2).

One Board Member emphasized the importance of increasing coordination with other development partners in-country to address shortcomings of the country team. *The Global Fund is currently doing stakeholder mapping at the country level so that the network of partners is clear. For now, at least, country teams are staffed with very bright people that regularly visit the country* (GFBoard5). GFBoard2 suggested that some of these concerns could be addressed with clearer expectations for a Fund Portfolio Manager and more effective coordination among constituents. Essentially, there needs to be changes in the hiring of Fund Portfolio Managers combined with diffused powers in oversight of grant implementation.

#### *In-country coordination*

Coordination among donors is central to the harmonization pillar of the Paris Declaration as one of three principles to avoid duplication (OECD, 2005). As a result many countries have



coordinating bodies comprised of bilateral and multilateral agencies that work with the host government and domestic non-governmental stakeholders for increased coordination and health development effectiveness. Mozambique has a Health Partners Group that meets monthly and brings together all health sector supporters, including representatives of civil society. In 2008 Mozambique signed an International Health Partnership (IHP+) compact (IHP+, 2008). It is a commitment among partners to harmonize and align their support with nationally defined priorities (to the extent that their procedures allow). A Global Fund Board Member identified IHP+ as *the most important opening that we have right now* (GFBoard3) for increased coordination and collaboration with other development partners.

Many more coordinating bodies have been created in Mozambique as a result of absorption challenges. These include the G19 (a group of bilateral donors who provide sector-wide support and coordinate among themselves), the National AIDS Council (Conselho Nacional Contra o SIDA), NAIMA+ (NGOs coordinating body), etc. As one donor representative put it, [the coordinating bodies] *in Mozambique they are a nickel a dozen! This is due to a very weak civil society. If you get an organogram of the Ministry of Health, you will see so many directors and sub-directors, but not many technicians* (GFCountryStructure2).

This has led to conventional donors and local officials spending exorbitant time on coordination, rather than on implementation issues. Coordination among different ‘market players’ involves notably high transaction costs (Coase, 1937). Yet, integration into a single organization with unified goals involves either high bureaucracy costs (Williamson, 1975) or requires very strong leadership (Selznick, 1949).

The Global Fund reportedly uses effective coordination as a criterion for grant approval. *The success of the application for Phase II of Round 9’s grants for HIV/AIDS and malaria was contingent upon the coordination among partners. So, effective coordination among partners is recognized as a potential weakness in Mozambique* (Coordination1). However, as there is no country presence, the Global Fund itself doesn’t participate in coordination bodies. Engagement with the Health Partners Group would greatly enhance the Global Fund’s understanding of country-level activities as this coordination body is *a clearing house of what each partner is doing* (OECDPartner3).

All respondents who represent the Global Fund agreed that coordination at the country-level is vital for successful implementation. A member of the Secretariat commented on coordination as if it is integral to the nature of the Global Fund’s engagement. *We are a contribution model*

*and impact only really occurs when you've got other donors in the national program also contributing* (GFSecretariat2). The picture painted by most country-level respondents was very different. Only one participant suggested that s/he was satisfied with the Global Fund's influence on country-level coordination. *Programmatically they brought a new approach. They forced partners to coordinate more* (Multilateral2). Decision-makers at the Global Fund did voice the need for improvement. Few specifically mentioned country-level coordinating bodies, but they recognized that the only way to avoid duplication is through coordinating with other actors. *There's definitely more to be done. Fortunately, it's moving in the right direction. It's crazy to think you can do appropriate due diligence of a proposal for funding to the Global Fund if you don't understand what other people are already funding* (GFBoard2).

The Health Partners Group reaches out to the Global Fund (Multilateral2, Multilateral4). *There is an attempt to communicate openly and freely with the Geneva headquarters. The Global Fund portfolio manager is included on the Health Partners Group listserv, so there is a somewhat formalized channel* (OECDPartner2). But Global Fund representatives do not seek contact with the Health Partners Group when they are in the country (OECDPartner3). *As there is no presence on the ground, coordination with donors is completely dependent on the interest and initiative of the Fund Portfolio Manager* (GFBoard4). Overall respondents expressed frustration about the Global Fund's lack of coordination; this was a near-universal theme at the country-level. This was mirrored by GFCountryStructure1's reflection that the *main criticism during the rounds-based model- the lack of coordination with in-country partners*.

At times commentary about country-level coordination bled into discussions on the Global Fund's partnership paradigm.

*Bilateral donors do have individual coordination, and interaction, with the country-level Global Fund bodies. For example, in Tanzania, the Global Fund initially interacted exclusively with PEPFAR [the US President's Emergency Plan for AIDS Relief]. Global Fund provided the money and the resources and PEPFAR was essentially overseeing implementation* (GFBoard4).

The Global Fund's challenges with coordination are not unique among implementing agencies in any field of development nor is Mozambique's ineffective coordination unique among recipient countries (manuscript in preparation). Rather these challenges are symptomatic of a widespread trend in development assistance in most sectors (Mwisongo and Nabyonga-Orem, 2016, Lawson, 2013).

The Global Fund strongly emphasizes partnerships with technical and development partners for governance and in-country efforts. Partners offer technical expertise, support resource mobilization and advocacy efforts, provide or support country coordination, assist with stakeholder engagement, and provide M&E for Global Fund-supported programs (The Global Fund, 2016r). The assistance provided by partners varies by country, but these partnerships are one more mechanism that the Global Fund uses to support grant recipients without a country office.

### *Partnerships*

The two largest donors to the Global Fund, the United States and France, both contribute five percent of their pledges to technical assistance (TA) (The Global Fund, 2016o). The five percent is channelled through their bilateral development agencies or their respective technical bodies founded to support Global Fund principle recipients- Grant Management Solutions and Initiative 5% (GMS, 2016, Initiative 5%, 2016). Additionally, the Global Fund works closely with partners to facilitate technical cooperation for countries at any stage in the grant process. Countries can request support for CCM functioning; strengthening the involvement of key populations; health systems strengthening; operational support; community, rights, and gender considerations; and grant management (The Global Fund, 2016s). In short, partnerships perform the functions that would otherwise be carried out by technical officers housed in country offices.

Information, personnel, finance, equipment, and supplies are all forms of TA for which applicants are eligible (Averett and Rivers, 2004). The latest published list of providers of technical assistance was in 2004 (Averett and Rivers, 2004). At the time there were 170 Global Fund-related technical assistance providers (135 organizations and 35 technically-qualified individuals). At the time of writing, the Global Fund website listed six organizations that offer TA. Aside from requests for technical cooperation on community, rights, and gender issues, the Global Fund encourages direct contact with TA providers (The Global Fund, 2016s). *The consultants hired to advise countries on strategies for their concept note development are paid by the partners. ... There is a lot of money flowing for Global Fund engagement that is not accounted for. ... These activities are coordinated at the country level, at the Development Partners Group* (GFBoard4).

The technical support provided by partners is an integral component of the principle recipients' success and, therefore, the Global Fund's success. *The amount of support buttressing the Global*

*Fund's activities depends on the country (GFCountryStructure1). In Mozambique, [w]e still have to rely on external consultants to develop our proposals (Multilateral2). Discussions in Geneva revealed that there is tension among stakeholders regarding reliance on technical partners and how these relationships are financed. On the one hand, if the Global Fund is not going to develop its own technical capacity, it has to be able to rely on useful, helpful, actionable guidance from the partners and I think that has been a real problem (GFBoard2). Furthermore,*

*The big problem has been basically from the creation of the Fund that technical partners are very important; they are the ones who are present on the ground ... And many of the countries depend on the technical assistance and the guidance from these technical partners. ... It works already quite well in some countries and less well in others. And the challenge is to get more consistent, let's say, quality of technical assistance provided by these partners (GFSecretariat1).*

Interviews in Mozambique revealed that partners do more than provide TA, they also step in to fill gaps. *When there are delays / gaps with the Global Fund, other donors step in for support. The other donors' responses are not formally decided or premeditated (OECDPartner6).* The US government is the largest donor in the health sector; they provide more development assistance for health than all other donors combined (GFCountryStructure2). They often fill gaps in Global Fund support due to the fact that they are both Mozambique's and the Global Fund's largest investor.

*The US government is very invested in Mozambique's success with the Global Fund ... The US government is the most involved of all the Global Fund donors both financially but also in terms of coordination at the project-level. All of Global Fund's activities on the ground in Mozambique are coordinated with PEPFAR and the President's Malaria Initiative [PMI] (OECDPartner6).*

In Mozambique the US government even has a Global Fund Liaison on the payroll. This position was *created to increase coordination of Global Fund with PEPFAR and [PMI] The position is pay-rolled by USAID, PEPFAR, or US Centers for Disease Control [CDC] depending on the country (OECDPartner1).* Respondents expressed confidence in the liaison and saw the position as the best window into Global Fund support. Without the oversight usually afforded by a donor, the liaison provides the best channel of communication between the Global Fund and some of the partners working in-country. It is an improvised mechanism of in-country coordination. One interviewee contrasted it with the intended mechanism of coordination. *The Global Fund liaison is more effective than the Country Coordinating*

*Mechanism because the members of the [CCM] are not actually paid; if the [CCM] were to become institutionalized, it would result in a parallel system (Multilateral5).*

It was unclear if this position is financed with the US Government's budget line for five percent of its commitment to the Global Fund through technical assistance. By all accounts, the US is the bilateral partner with whom the principle recipients and Global Fund stakeholders most often coordinate and communicate with. For example, *The Portfolio Managers communicate directly with [PMI] whereas the Global Fund liaison communicates with the Country Coordinating Mechanism (OECDPartner6).*

This degree of support from the US government has been invaluable in Mozambique. They are able to identify gaps early on and provide additional support as needed. *The National HIV/AIDS Acceleration Plan [financed by the Global Fund] ... is projected to have a massive gap in commodities procurement, which the US government will ultimately need to fill (OECDPartner6).* But interviewees also shared concerns of when the agenda of the US government and the other donors do not align.

*US Congress sets specific targets ... that make it imperative for US development activities to follow their own goals. Otherwise Congress will cut funding. ... US funding has far more constraints and accountability rules, so that little of it goes directly to the Mozambican government. PEPFAR has a more efficient implementation machine, but –indeed—perhaps the long-term coordination suffers (GFCountryStructure2).*

This response was independently supported by other interviewees (OECDPartners 2 and 3) who touched upon donor relations in Mozambique and the disagreement among the G19 about expectations to hold.

*US government recognizes that Mozambique has weak systems and provides support for the system so as not to set them up to fail but expects them to be a genuine partner and makes changes based on lessons learned. The Global Fund expects the Ministry of Health to apply for funds and then take a “do-it-yourself” approach to systems strengthening, but this fails because they need support (OECDPartner2).*

Some partners question the boundary between the US government and the Global Fund. *In Mozambique criticizing the Global Fund is criticizing US government assistance (OECDPartner10).* Based on discussions with Board Members in Geneva about partners providing TA on the ground, this concern extends up to the highest levels and is perhaps not unique to Mozambique. *Sometimes, it's not only a question of wanting something, it's (a question of) what does USA believe in? (GFBoard1).* The US government, in particular, holds

a lot of power in Global Fund's activities in-country, so their own approach, mandate, and philosophy are highly relevant in how the Global Fund operates in Mozambique.

A member of the Secretariat inadvertently reinforced the prospect that there is enmeshment of Global Fund and US government agendas at the highest level. When asked if Global Fund's donors are coordinating to maximize their contributions the interviewee only discussed coordination with the US government (USG). *The Global Fund has formed a partnership with PEPFAR to avoid duplication. ... The USG focuses on service delivery and community-level interventions, and the Global Fund works at the national level* (GFSecretariat5). It is unclear from GFSecretariat5's response at what level the US government is supposed to share knowledge, and with whom exactly.

The degree of external support required for the Global Fund's success has raised a debate on accountability. To whom are the providers of TA held accountable?... *the most difficult part of the Global Fund model is the partnership model. It depends on the support of partners and yet it doesn't have any say over the partners. ... I think we need to figure out what that relationship should be* (GFBoard2).

In Mozambique this blurry line extends to the Ministry of Health. *The US government pays for the Global Fund Unit in the Ministry of Health* (OECDPartner6). It's in the Department of Planning and Coordination and is responsible for coordinating Global Fund projects.

*From 2002 to 2007 the Ministry of Health had a coordinator and a financial assessor who acted as focal points for the Global Fund [presumably paid for from Global Fund grants]. From 2007 to 2008 the positions were paid for by the Ministry of Health. Eventually an auditor asked the US government to pay for the entire Unit. ... The Country Coordinating Mechanism was not included in the formation of the Global Fund Unit [Memorandum of Understanding].* (GFCountryStructure4).

In terms of coordination, *the US government is the only bilateral donor that [the Global Fund Unit] has contact with* (GFCountryStructure4).

A new channel was created to manage Global Fund money in 2010/11 in response to the Global Fund's withdrawal from the health financing basket. Rather than going directly from the Ministry of Finance to the Ministry of Health, money goes through the Global Fund Unit. The combination of burdensome requirements and weak oversight has resulted in the need for an entire unit within the Ministry of Health. *Mozambique is an example of a country undergoing internal reform of reporting systems to adapt to Global Fund requirements* (GFBoard4). The fact that it is paid for by the US government means that it is accountable to the US government

and not the Mozambican government.

The Global Fund's lack of country presence results in inadequate coordination with in-country partners. It also necessitates support from technical partners, for example, the WHO, to address stringent performance-based funding reporting requirements. Additionally they require buttressing by bilateral donors who provide finance to the Global Fund and the countries in which it operates, for example, the US government (Table 20).

*Table 20. Summary of country-level perceptions of the Global Fund's paradigm*

<b>Aspect of paradigm</b>	<b>Perceived country-level result</b>	<b>Respondent(s)</b>
Performance-based financing	<ul style="list-style-type: none"> <li>recipients' focus on disbursement rather than results</li> <li>burdensome administrative requirements</li> <li>duplication of reporting efforts from the ground all the way to central level</li> </ul>	OECDPartner10 GFCountryStructure4 Multilateral3
Emphasis on financial technicalities	<ul style="list-style-type: none"> <li>staff with financial rather than development background who lack country experience</li> </ul>	GFBoard4
Lack of country office	<ul style="list-style-type: none"> <li>other partners doing monitoring for the Global Fund</li> <li>Global Fund is not engaged in country-level coordination</li> <li>forces partners to coordinate among themselves more</li> <li>frequent deadlines and time stress</li> <li>over-worked staff, communication challenges, out-of-touch with realities on the ground</li> <li>dependent on expertise and interest of single person (Fund Portfolio Manager)</li> </ul>	OECDPartner2 Coordination1, OECDPartner3 Multilateral2 GFSecretariat5 GFSecretariat5 GFBoard4, GFCountryStructure1, GF Secretariat5
Partnerships	<ul style="list-style-type: none"> <li>reliance on external consultants to develop proposals</li> <li>early identification of gaps and provision of additional support</li> <li>undefined roles and concerns about accountability</li> <li>potential for agenda alignment with single partner and less coordinated/multilateral approach</li> </ul>	Multilateral2 OECDPartner6 GFBoard2, GFCountryStructure4 GFBoard1, GFCountryStructure2, GFSecretariat5, OECDPartners2, 3, and 10



*Ability to reform*

Overall, there were mixed reviews on what the New Funding Model has, or will, actually change on the ground, but multiple interviewees referred to the Global Fund's *ability to reform* as one of the defining characteristics of the organization. It was a prominent, recurring theme in interviews.

*"Global Fund has proved in 10 years to have the ability to renew itself"* (Multilateral4).

*"The Global Fund's New Funding Model addresses inefficiency concerns, and the recent changes in the Global Fund have shown how international organizations are capable of re-inventing themselves"* (GFCountryStructure2).

*"Overall, the Global Fund is learning from its mistakes. ... the Global Fund, completed its reformation in one year. It is a 'learning organization'; it is navigating through a field of opposing forces, and is highly committed to its mission"* (GFBoard4).

Although many of the reforms have not yet addressed concerns about the Global Fund's overall model, interviewees seemed to be looking beyond this initial transformation. They spoke of prospective changes and solutions. The final remarks of two respondents who shared an interview were reminiscent of the tone and attitude of many respondents during discussions on the Global Fund. They clarified that although their responses were critical of the Global Fund, they admire the Fund's work (GFBoard4 and GFBoard5). This sentiment is linked to the organization's ability to reform- respondents can use opportunities such as interviews to share lessons learned about perceived strengths and weaknesses of the Global Fund with the hope that they are included in the next wave of changes.

*"I think there is commitment from the Secretariat as well certainly from our constituency and others to improve the Funding Model. As Mark Dybul is the first to say, 'we haven't got it all right', this will be an iterative process to continuously improve how the new funding model works"* (GFBoard2).

As one respondent pointed out, the continued success of the Global Fund in Mozambique is important because *the Global Fund is a means of getting around the government; the government does not necessarily reflect societal demands* (OECDPartner3).

## 6.5 Conclusion

In Mozambique the Global Fund is viewed as an institution that is uniquely capable of reform. Despite the changes with application processes that are associated with the New Funding Model, respondents in both Geneva and Maputo firmly believed that challenges remain in the inherent structure and paradigm of the Global Fund. The lack of a country office has many negative downstream effects including reliance on partners in-country. Due to weak managerial and absorptive capacity, more oversight is required than is afforded by country team visits. In-country partners provide much needed support for Global Fund recipients, but roles, responsibilities, and accountability must be clearly defined for a successful long-term partnership paradigm. Furthermore, decision-makers in Geneva recognize in-country coordination as vital to successful implementation, and other actors in-country would welcome Global Fund engagement. To date, there are no institutional requirements for formalized coordination, and at the time of the interviews the Global Fund has no consistent representation in any in-country coordination groups.

Although the Global Fund's decision against having local offices may be justified, the various downstream difficulties suggest that the Global Fund should adopt a more conscientious approach by adapting grant implementation and monitoring procedures to the specific local realities. It should establish procedures that allow room for flexibility while remaining harmonized with headquarter demands. This shifts the onus to headquarters to assess whether what a country reports meets the requirement. The Global Fund could couple these changes with a policy for formalized coordination in-country.

## 6.6 Take-home messages

- The lack of a country office has many negative downstream effects including over-reliance on partners in-country.
- Although partnerships provide much needed support for Global Fund recipients, roles, responsibilities, and accountability must be clearly defined for a successful long-term partnership.
- The Global Fund emphasizes coordination at the higher levels of the organization, but country teams' engagement with other actors in-country is dependent on the Fund Portfolio Manager.
- The Global Fund's ability to reform is seen as unique, and respondents see its approach as continually evolving.

## 6.7 Acknowledgements

The authors would like to thank all participants for their time and interest in responding to interviews and follow-up. The authors would also like to thank Stephen Browne, Prof. Raymond Saner, Lichia Yiu, and Shufang Zhang for their contributions to this research by conducting interviews through the SNIS project. We would also like to thank Olivia Meira and Giovanna Centeno Barbalho for translating the abstract, conclusions, and take-home messages into Portuguese. This work was funded by the Swiss Network for International Studies (reference # 3938) and the Swiss Tropical and Public Health Institute.



## 7. Discussion

### 7.1 Synthesis

This thesis serves to illuminate the nature and influence of development assistance for health from three types of emerging donors in sub-Saharan Africa – private donors, emerging economies, and global health initiatives. To date, philanthropic foundations, corporations, and emerging economies remain complementary to bi- and multilateral agencies for DAH. On the other hand, the Global Fund is one of the most important actors in the fight against AIDS, tuberculosis, and malaria. Despite the range of influence amongst these emerging donors, they are all absent from case-study country-level coordination groups.

The Global Fund has become one of the most important sources of development assistance for health in 14 years in terms of both volume and success. It has undergone reform in recent years (The Global Fund, 2013b) but country-level stakeholders identified challenges that persist. The lack of a country office has many negative downstream effects including over-reliance on partners in-country. Although partnerships provide much needed support for Global Fund recipients, roles, responsibilities, and accountability must be clearly defined for a successful long-term partnership. Respondents were eager to discuss Global Fund challenges stemmed, in part, from their perception that the Global Fund has the unique ability to reform. The recent changes give hope that future iterations of reform could include changes to the structure and governance of the Global Fund.

The Global Fund is an example of an emerging donor that has successfully integrated into high-level governance structures. It participates in international efforts to standardize financial tracking by reporting to the OECD and International Aid Transparency Initiative (OECD, 2016g, IATI, 2016b) and is considered to provide high quality assistance (CGD, 2016).

Discussions about philanthropic foundations and CSR programs focused on alignment and harmonization. These are principles that were included in the first declaration on aid effectiveness but were de-emphasized in later iterations (OECD, 2005, Fourth High-Level Forum on Aid Effectiveness, 2011). Emerging donors were not included in high level discussions until recently which potentially explains their seeming unfamiliarity. As a result private donors are not necessarily aligned with country priorities or strengthening country health systems and currently contribute to fragmentation due to their narrow focus.

Respondents in the case-study countries highlighted that the BRICS countries are not the only emerging economies active in the health sector. Due to the lack of coordination of these newer actors, development partners were largely unaware of specific engagements or influences. The scale of their engagement remains unclear. Overall, the BRICS are still perceived to be focused on investment opportunities rather than development priorities. Some governmental officials welcome the support of the emerging economies as it can be quicker and fill gaps, but many development partners are sceptical of the sustainability of their support and long-term implications for social welfare. Interviewees identified many challenges in working with emerging economies, but many agree that their resources are needed to meet development goals.

Private donors and emerging economies are not held to the same standards as conventional donors in terms of regulation, policies (e.g. submitting reports to the Ministry of Finance is mandatory for conventional donors, but is voluntary for unconventional sources in Tanzania). This culture of more relaxed standards begs for more stringent transparency measures.

Transparency of emerging donors' financial flows is not only important for understanding the volume of assistance these actors provide, but also to mitigate potential corruption. Recent reports have shown that illicit capital flows, including trade mispricing, have left Africa a net creditor (Kar and Cartwright-Smith, 2013). There are many country-level concerns that are associated with illicit flows- dependence on natural resource extraction, tax incentives not appropriately ascribed, lack of transparency, political corruption, and capacity to name a few (Hamdock et al., 2015). Multinational corporations and the BRICS bloc, which is Africa's largest trade partner and biggest new group of investors, are in the perfect position to spearhead transparency and accountability efforts to reduce the draining of capital from Africa.

By 2011, more than US\$1 trillion was leaving developing nations annually, with over 83 percent attributed to deceitful trade invoicing (Kar and Spanjers, 2015). To put this in perspective, in 2012, "for every dollar of ODA that entered the developing world in 2012, ten dollars flowed out illicitly" (Kar and Spanjers, 2015). Between 2004 and 2013 in sub-Saharan Africa alone an estimated US\$675 billion was lost (Kar and Spanjers, 2015). Though this only represents 8.6 percent of the total, when illicit flows are scaled as a percentage of GDP, sub-Saharan Africa is the region most affected with illicit flows averaging 6.1 percent of the regions' GDP (Kar and Spanjers, 2015). These illicit flows are especially important in light of the fact

that countries are expected to mobilize more domestic revenue for health to supplement declining ODA.

OECD bilateral agencies provide support to transparency initiatives, civil society efforts, tax fora, and multilateral initiatives (OECD, 2014b). But this responsibility extends beyond providers of official assistance, specifically to corporations themselves and emerging economies who are important trade partners for many developing countries. The first step is enhanced transparency.

Additionally, official development assistance for health has shown some volatility in recent years, and emerging donors may find themselves playing a larger role than they had originally intended. The development community has adapted to the global financial crises, but soon it may be faced with shortages due to political crises in OECD countries. Brexit, the recent US presidential election, and predictions about upcoming French and German elections all highlight a widespread nationalist trend that among other consequences, could directly affect bilateral assistance programs. This places even more importance on developing best practices and increasing inclusivity in aid effectiveness fora.

Recent political changes in the United Kingdom and the United States also foreshadow potential threats to global development progress. Both countries experiences illustrate the worrying trend of increased nationalism. In mid-2016 the United Kingdom voted to withdraw from the EU in what is known as Brexit. Since then there have been speculations about what this will mean for development priorities and EU development assistance (Watkins, 2016, Green, 2016). Of particular concern is the prediction that it will abandon its commitment to 0.7 percent of its GNI on development assistance (Barder, 2016). Likewise, the 2016 US Presidential election has raised concerns about the incoming administrations priorities including development. So far, reports are focused on domestic concerns, but experts will likely share their predictions in the months ahead. One bright spot in the scenario is that in both cases, polls show that young voters were against these nationalist trends (BBC, 2016, Mosendz, 2016).

## **7.2 Overall significance of research**

The guiding principle of the Swiss Tropical and Public Health Institute is to work in interdisciplinary partnership to respond to local, national and international public health priorities. It aims to identify solutions through innovation (discovery through promotion and testing of hypotheses), validation (evidence promoting what works) and application

(strengthening individual and public health actions, systems and policies). Therefore it is essential to map the findings of this thesis against these aims.

*Table 21. Research findings within the Swiss TPH research pillars*

<b>Chapter</b>	<b>Innovation</b>	<b>Validation</b>	<b>Application</b>
4	Capturing country-level perspectives on engagement with philanthropic foundations and corporate social responsibility programs	Researchers must find another entry point to quantify contributions effectively	Dialog on aid effectiveness must be more inclusive, and the principles must be more comprehensive
5	Capturing country-level perspectives on emerging economies in development cooperation	Researchers must find another entry point to quantify contributions effectively	Dialog on aid effectiveness must be more inclusive, and the principles must be more comprehensive
6			The Global Fund should heed country-level concerns about operational and governance challenges

We found that studies on emerging donors of development assistance for health need to find a different entry point to quantify and qualify contributions. Interviews and document review are insufficient. Funds from philanthropic foundations often enter recipient countries through non-governmental organizations obfuscating their contributions. There is a lack of disaggregated data on websites and annual reports. Additionally many private financiers are part of complex networks of other donors, recipient organizations, and implementing bodies; this prevents monitors from teasing apart flows without proper network analyses.

This study highlighted existing gaps in donor-donor coordination and recipient-donor coordination, despite the proliferation of coordinating bodies. There also appears to be a lack of understanding about emerging donors overall influence on communities' health through investments affecting the social determinants of health. The themes of this project could be further pursued through interviewing and exploring selected relevant emerging donors- both BRICS and non-BRICS countries, philanthropic foundations, and corporations with active corporate social responsibility programmes in each of the case-study countries.

The Global Fund is entering a new phase. It received its fifth replenishment and is seeking a new Executive Director for 2017. The findings of this thesis provide insight on existing country-level challenges.



Overall, our findings are useful for highlighting the challenges associated with investigating the nature of development assistance.

### 7.3 Limitations

There are a number of limitations to consider with this dissertation. We expected to unearth quantitative data on financial flows for the four case-study countries to supplement the wealth of qualitative data gathered in interviews. No interviewees, including those from the Ministries of Health, could, or would, provide exact figures. Chad's Ministry of Finance was the only governing body that provided budgetary data; unfortunately, no donor funds go through the public sector, so it was not useful in our study. This unexpected result illuminates the lack of transparency, or country-level awareness, of newer sources of external finance.

We also expected conventional development partners to be more aware of the presence and activities of emerging donors. It is difficult to gauge whether or not this is a pitfall in current donor coordination efforts (both amongst themselves but also with the recipient governments) or because the emerging donors provide more support for social determinants of health rather than development assistance directly for health, etc. As we were interested in the *perception* of emerging actors' influence, we did not engage directly with representatives from philanthropic, corporate social responsibility, or the emerging economies. If time had allowed, it would have been interesting to follow-up with the donors themselves as a supplement. Data was collected as part of a larger study on the influence of emerging donors in health development (SNIS, 2012). It was a two-pronged look at the influence of emerging actors in health assistance: ground-level experiences and global governance. Therefore one team of interviewers conducted interviews at Geneva-based institutions and were able to capture perspectives from the Global Fund that were relevant in this study on country-level perspectives.

There were also limitations to the interviews themselves. There was one interview lead in the case-study countries and one interview lead in Geneva. A different co-interviewer accompanied the lead in each case-study country. (Likewise this same team of four rotated for the Geneva-based interviews, based on availability.) The team is composed of four development professionals with different backgrounds (trade, etc). The interview guide (see Annex 1. Semi-structured interview guide (for health ministry officials) provided structure and topics that needed to be covered, but the interviews were conducted with different lenses and steered by different interests. Additionally, the interviewees at times appeared to use the interviews as a chance to vent their frustrations on the state of development assistance for health in-country.

This frustration might have restricted the range of the perspective communicated to interviewers.

Last but not least, are the limitations of conducting research and reporting results on the rapidly changing landscape of development assistance for health. This research was conducted during the transition from the Millennium Development Goals to the Sustainable Development Goals, in the aftermath of the largest global recession in recent history, and during volatile political climates in donor and recipient nations. The nature and influence of development assistance for health is itself guided by these rapidly changing spheres of power. The snapshot captured in 2013-2014 could be dramatically different from a snapshot captured at the time of publication in 2016.

## 7.4 Recommendations and Future Research

### *Practical and policy recommendations*

- National Health Accounts are an internationally accepted framework to track expenditure on health to guide policy-making (WHO, 2016c). They primarily focus on financial flows for health services and break down domestic sources into public and private and also include development assistance for health. Unfortunately, many countries do not yet produce NHAs and those that do only publish every three to five years (when a country publishes them at all). In terms of development assistance for health, the data presented is aggregated and is not broken down by donor, nor do they include external sources of private finance or the emerging economies. NHAs should be modified to include emerging sources of finance and should be updated on a more regular basis to be a more useful tool of who is contributing to health in any given country.
- In an ideal world, emerging donors would publish their aid data with the International Aid Transparency Initiative (IATI), a voluntary, multi-stakeholder initiative that aims to increase aid effectiveness through increasing aid transparency (IATI, 2016a). Government donors, private organisations, and NGOs are called to report their aid data in a standardised framework. There are currently 496 publishers on IATI. Of these, 21 are foundations (up from seven in 2015), 30 are classified as “private sector” (up from 12 in 2015), three are public private partnerships (up from two in 2015; the Global Fund

is classified as a multilateral organisation), and none are emerging economy bilateral donors.

Unfortunately only 17 of 34 OECD countries report to IATI, so putting international pressure on emerging donors will be ineffective if conventional donors are not complying. At the very least emerging donors should be encouraged to report against global standards like the OECD-DAC. Additionally, the OECD-DAC databases would be more useful for understanding aid flows, if donors were required to submit data with a lower level of aggregation.

As of yet there are no real incentives for donors to increase their transparency or accountability. Perhaps the most effective approach would be for the international development community to design a standardised rubric to be included in routine auditing of bilateral donors- a separate section dedicated to aid effectiveness. In light of ongoing economic volatility, it is also in the best interest of donor governments and taxpayers to ensure that their aid agencies avoid internal duplication and non-evidence-based programming.

While there are a number of actions that the BRICS can take individually- such as establishing formal, centralized institutions for their foreign assistance programs- there are initiatives they could approach collectively to have an enormous impact on the global health landscape.

- Brazil, Russia, India, China, and South Africa represent five of the six WHO regions- Region of the Americas, European Region, South-East Asia Region, Western Pacific Region, and African Region; respectively. This positions each country to serve as a hub for a number of key health activities.

Regional Health Observatories would facilitate evidence-based decision-making through the compilation and management of regional health statistics, coordination of regularly updated health system profiles, and tailor-made national and regional policy briefs. While smaller, scattered public health observatories exist, the European Region currently hosts the only WHO regional health observatory (WHO, 2016a). Such a network in each region would facilitate strong partnerships between governments, academic institutions, and international institutions for generating appropriate strategies for health investment. Reports provide detailed assessments of pre-defined health indicators and outcomes while measuring health sector performance and evaluating health programs. Observatories allow for streamlined data management; if indicators are standardized and rationalized, they could provide a framework for alignment with

donors to minimize duplication of effort in reporting routine data, including burden of disease. These observatories should also be responsible for organizing national health accounts, hosting health and demographic surveillance systems, serving as sentinel sites for outbreak surveillance, and promoting the collection of vital statistics and cause of death data. The already entrenched BRICS network would provide a platform for trans-regional communication on lessons learned.

- Brazil, Russia, and China are three of the world's largest players in the extractive industry, both domestically and abroad. They are in the position to revolutionize the regulation of the industry. Due to the magnitude and pervasiveness of the extractive industry, it is important that institutionalization of health impact assessment (HIA) becomes more universal (Lee et al., 2013) and ensure that the corporate social responsibility arm of the industry coordinates with the national health system. Brazil has formalized HIA, but the BRICS need to more fully integrate and formalize impact assessment as a part of their foreign assistance agenda (Winkler et al., 2013). The data gathered during the health impact assessment should naturally be submitted to the national data repository. Corporate social responsibility programs associated with the extractive industry often times set up parallel health systems for their employees. While it is commendable that the employees have access to quality services, if approached differently, the same resources could be used to strengthen the local system to leave a more sustained legacy of good health in the community.
- The Global Fund should adopt a more conscientious approach by adapting grant implementation and monitoring procedures to the specific local realities. It should establish procedures that allow room for flexibility while remaining harmonized with headquarter demands. This shifts the onus to headquarters to assess whether what a country reports meets the requirement.
- The Global Fund should create a policy for formalized coordination in-country. Initially the Country Coordinating Mechanism (CCM) was established, in part, to act in this capacity. Our research corroborates Global Fund OIG findings that this mandate has not been satisfied (The Global Fund - OIG, 2016). E.g. *58% of the CCMs had not shared oversight reports with country stakeholders and The Global Fund Secretariat in the previous six months.* As the Global Fund extends its reforms beyond the application

processes, it could create a policy, with accountability measures, that specifies a position within the CCM that is responsible for attending health partners group meetings, providing a comprehensive and exhaustive update of current Global Fund grants and upcoming applications to the health partners group, and communicating the agenda and outcomes of each health partners group meeting to the rest of the CCM and the country team.

### *Further research*

- **Emerging donor engagement from their perspective.** Our study was interested in understanding how new partners are engaged with recipients from the country-level perspective. This study highlighted gaps in donor-donor coordination and recipient-donor coordination and potentially gaps in understanding about emerging donors overall influence on communities' health through investments affecting the social determinants of health. The themes of this project could be further pursued through interviewing and exploring selected relevant emerging donors- both BRICS and non-BRICS countries, philanthropic foundations, and corporations with active corporate social responsibility programmes in each of the case-study countries.
- **Network analysis / partner mapping.** Recipient countries have increasingly complicated partnership landscapes. In Mozambique, there are 38 members in NAIMA+, the NGO coordination body. Between these 38 members there are more than 90 unique sources of funding and more than 190 unique operating partners. It is impossible to understand such complex interactions of donors, recipients, and operational partners without a proper network analysis to understand where money goes.
- **Agenda-setting with new donors.** How are agendas set between recipient governments and emerging donors? Conventional donors have long-standing relationships with the countries in which they operate and therefore have “institutional memory” for agenda-setting. How are new partnerships formed and finalised? How are agendas and priorities set? Who approaches whom for investment?
- **Policy analysis of changes associated with bilateral aid agencies' shift to Ministries of Trade.** The international community expressed concern about Canada and

Australia's recent re-structuring of their Department/Ministry of Foreign Affairs. CIDA and AusAID were reorganised and housed within their countries' Ministry of Trade. Concerns focus on how this will affect central-level resource allocation and to what extent priority setting for development assistance will be overtly linked to trade interests. Norway, the Netherlands, and Denmark have all alternated between having independent aid agencies and aid agencies housed within the Ministries of Trade. What actually changes besides politics and internal re-structuring? Were these organisational changes accompanied by significant changes in development policy?

- **Capture resources for health development research.** Health development research often includes capacity building through training. Additionally it introduces new equipment and information and communication technology, it sponsors treatment administration, provides health commodities (e.g. ARVs, antimalarials, insecticide treated bednets), and introduces financing mechanisms such as vouchers. Others introduce complex, system-level interventions that provide support across the six health system building blocks (governance, finance, human resources, information, medicines and technologies, and service delivery). These investments should be tracked and considered amongst the financial flows for health.

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## 9. Annex

### 9.1 Annex 1. Semi-structured interview guide (for health ministry officials)

#### **Overview**

What have been the most influential shifts of external finance for health channelled through your Ministry (in terms of source and magnitude)?

How have these affected resource allocation and the budget for health at the national level?

Were the increases in assistance for health added to the budget or did the funds acts as a substitute? If yes, in which area?

Have changes in development assistance for health led to an increase in interaction and coordination between the Ministries of Health, Finance, and Foreign Affairs in terms of communication and/or resource flows? If yes, please describe. (Follow-up: who initiates such coordination? Is the coordination formalized? What are the mechanisms? Results?)

#### **BRICS bilateral**

As defined by the G77's Ministries of Foreign Affairs meeting in 2009, South-South Cooperation includes five key elements. Could you comment on how your Ministry experiences BRICS partners in terms of the following:

- a) Partnership;
- b) Avoiding policy conditionality in governance, economic policy, or institutional reform;
- c) Structuring assistance to compliment foreign direct investment;
- d) Emphasizing individual project feasibility rather than long-term debt sustainability;
- e) Applying domestic development lessons?

Many of the BRICS countries emphasize technical cooperation rather than financial assistance; how do you experience this within your Ministry? Example?

Is this a valued approach?

What are the key influences of this finance channel on national health governance?

#### **Private finance**

Could you comment on how your Ministry experiences private and/or philanthropic partners for health in terms of the following:

- a) Partnership;
- b) Avoiding policy conditionality in governance, economic policy, or institutional reform;
- c) Structuring assistance to compliment direct investment;
- d) Emphasizing individual project feasibility rather than long-term debt sustainability;
- e) Applying domestic development lessons?

What are the most notable differences in your Ministry's experience of private and/or philanthropic partners for health when compared to conventional bilateral or multilateral partners?

What are the key influences of this finance channel on national health governance?

#### **International Organizations**

Could you comment on how your Ministry experiences public and/or private partners- such as the Global Fund, the GAVI Alliance, Medicines for Malaria Venture, and the World Health Organization- in terms of the following:

- a) Partnership;
- b) Avoiding policy conditionality in governance, economic policy, or institutional reform;
- c) Emphasizing individual project feasibility rather than long-term debt sustainability;
- d) Applying domestic development lessons?

What are the most notable differences in your Ministry's experience of public and/or private institutions when compared to conventional bilateral or multilateral partners?

What are the key influences of this finance channel on national health governance?

### **Concluding**

How does your Ministry record in-kind assistance for health in the mid-term expenditure framework?

Are there structural/institutional changes needed within your Ministry for effective harmonization of these diverse assistance channels?

Are there any other key points or concerns related to our project that you would like to share?



## **9.2 Annex 2. Non-BRICS emerging economies' activities in-country**

	<b>Chad</b>	<b>Ghana</b>	<b>Mozambique</b>	<b>Tanzania</b>
<i>Colombia</i>				<ul style="list-style-type: none"> <li>• tripartite collaboration, with Mexico (TZAcademic2)</li> </ul>
<i>Cuba</i>	<ul style="list-style-type: none"> <li>• physicians; salaries paid by Chad (TDConsultant1, TDOECDPartner1)</li> <li>• partnership for HSS is directly through health ministry (TDMultilateral1)</li> </ul>	<ul style="list-style-type: none"> <li>• physicians; salaries paid by Cuba (GHAcademic1) or subsidized by Ghana (GHMultilateral6)</li> <li>• training (GHMultilateral6)</li> <li>• technical assistance for malaria control (GHGovernment2)</li> </ul>	<ul style="list-style-type: none"> <li>• physicians subsidized by Mozambique (MZGovernment1)</li> <li>• physician training programs (MZOECDPartner1)</li> </ul>	<ul style="list-style-type: none"> <li>• medical personnel for Zanzibar (TZMultilateral3 &amp; 4)</li> <li>• malaria prevention, through vector control (TZMultilateral3 &amp; 4)</li> <li>• physicians (TZOECDPartner7 &amp; 8)</li> </ul>
<i>Egypt</i>				<ul style="list-style-type: none"> <li>• physician training (TZOECDPartner4, 5, &amp; 6)</li> </ul>
<i>Iran</i>		<ul style="list-style-type: none"> <li>• nine hospitals (GHGovernment2)</li> <li>• first batch of ambulances (GHGovernment2)</li> </ul>		
<i>Islamic Development Bank</i>	<ul style="list-style-type: none"> <li>• supports universal health coverage (TDOECDPartner1)</li> </ul>			

<b>Chad</b>	<b>Ghana</b>	<b>Mozambique</b>	<b>Tanzania</b>
<i>Israel</i>	<ul style="list-style-type: none"> <li>• health infrastructure investment (GHMultilateral6)</li> <li>• training (GHMultilateral6)</li> </ul>	<ul style="list-style-type: none"> <li>• not specified (MZMultilateral5)</li> </ul>	
<i>Japan*</i>			<ul style="list-style-type: none"> <li>• strengthen capacity of regional medical teams / training and management (TZMultilateral3 and 4)</li> <li>• technical support (TZOECDPartner1)</li> </ul>
<i>Malaysia</i>			<ul style="list-style-type: none"> <li>• procuring essential medicines (TZConsultant2)</li> <li>• tripartite collaboration with India, build capacity in research, social determinants of health (TZAademic2)</li> </ul>
<i>Mexico</i>		<ul style="list-style-type: none"> <li>• not specified (MZMultilateral5)</li> </ul>	<ul style="list-style-type: none"> <li>• tripartite collaboration with Colombia (TZAademic2)</li> </ul>

<b>Chad</b>	<b>Ghana</b>	<b>Mozambique</b>	<b>Tanzania</b>
<i>Saudi Arabia</i>	<ul style="list-style-type: none"> <li>• medicines and sent (GHGovernment2)</li> <li>• personnel for technical assistance (GHGovernment2)</li> </ul>		
<i>South Korea*</i>	<ul style="list-style-type: none"> <li>• not specified, but included "predominant bilateral actors in health" (GHMultilateral2 and 3)</li> </ul>	<ul style="list-style-type: none"> <li>• physician training programs (MZOECDPartner1)</li> </ul>	<ul style="list-style-type: none"> <li>• infrastructure and capacity development (TZOECDPartner4, 5, and 6)</li> <li>• bring specialists to rural areas (6 months to a year) (TZGovernment5)</li> <li>• facilities for open heart surgery, planned follow-up training and equipment. (TZGovernment5)</li> </ul>
<i>Turkey</i>		<ul style="list-style-type: none"> <li>• not specified (MZMultilateral5)</li> </ul>	

## 10. CV

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#### Demonstrated Skills

- Team worker: remotely managing a decentralized team with collaborators spread over three cities in Switzerland and four sub-Saharan African countries.
- Developing close collaborations with both academic and non-academic professionals.
- Motivating others, delegating, and diplomatically managing projects.

#### Professional Experience

##### **2017-present: Development Director, AIM Center, Inc. (Chattanooga, TN)**

- Planning and implementation of all development activities including donor relationships, fundraising, events, outreach, community engagement, and marketing.

##### **2016-2017: Consultant, Association of Marshall Scholars (New York, NY)**

- Data collection and organization for building an online resource to showcase the intellectual products of Marshall Scholars
- Website development and maintenance
- Management and oversight of two interns
- Assistance with 2017 Harvard Marshall Forum which featured guest speakers such as Madeleine Albright and Supreme Court Justices Stephen Breyer and Neil Gorsuch

##### **2012-present: PhD candidate, Swiss Tropical and Public Health Institute (Basel, Switzerland)**

- Manager and lead researcher of four-country study in sub-Saharan Africa
- Lead interviewer and person-of-contact for high-ranking government officials and in-country development partners, including bilateral and multilateral organization, local NGOs, and coordination bodies
- Design and analysis of both qualitative and quantitative research projects

##### **2012: Consultant, University of Queensland, School of Population Health (Brisbane, Australia)**

- Consultant for Professor Alan Lopez, Head of School of Population Health
- Provided literature review and assessment services in preparation for commencement of the Asia-Pacific Research Observatory Hub project.
- Prepared health system summaries for Cambodia, Papua New Guinea, and Tonga (including governance, finance, information systems, human resources, medicines and technology, and service delivery).
- Prepared Asian Pacific-specific adaptation of the WHO Health in Transition health

system template including defined core indicators.

**September-December 2011: Research Assistant, Swiss Tropical and Public Health**

**Institute**, Health Systems Research and Dynamic Modeling Unit, Department of Epidemiology and Public Health, University of Basel, (*Basel, Switzerland*)

- Assisted with background research and grant-writing for multiple projects while writing manuscript on findings from MSc thesis (see Publications below).

**2008-2009: Post Baccalaureate Scholar, National Institutes of Health**, Division of Human Bacterial Pathogenesis, National Institute of Allergy and Infectious Diseases - Rocky Mountain Laboratories (*Hamilton, Montana, USA*)

- Investigated the pathogenicity and virulence of Methicillin-Resistant *Staphylococcus aureus* (MRSA), as well as why and how human neutrophils seem to imperfectly process MRSA.
- Worked on multiple projects including the characterization of a gene found in human neutrophils that is up-regulated during MRSA phagocytosis.

## Education

**2012-present: Swiss Tropical and Public Health Institute**, Switzerland

- PhD in Epidemiology
- Country-level perspectives of emerging donors for health in Chad, Ghana, Mozambique, and Tanzania
- Supervised by Don de Savigny and Marcel Tanner

**2009-2011: Swiss Tropical and Public Health Institute**, Switzerland

- MSc in Epidemiology and Infectious Disease
- Analysis of Global Fund investments in governance, finance, information, human resources, medicines and technology, and service delivery.

**2001-2008: University of Montana**, USA

- BA in Cellular and Molecular Biology
- Lead researcher on project investigating genome evolution of the opportunistic pathogen *Pseudomonas aeruginosa* in the lungs of cystic fibrosis patients (see Publications).

**Proficiency in software packages:**

- Microsoft Office, MaxQDA, NVIVO, STATA

## Publications

Warren, A.E., Wyss, K., Shakarishvili, G., Atun, R., and de Savigny, D. (2013) **Global health initiative investments and health systems strengthening: A content analysis of Global Fund investments.** *Globalization and Health*. 9 (30).

Warren, A.E. et al (2011). **Genotypic and Phenotypic Variation in *Pseudomonas aeruginosa* Reveals Signatures of Secondary Infection and Mutator Activity in Certain Cystic Fibrosis Patients with Chronic Lung Infections.** *Infection and Immunity*. 79(12): 4802-4818.

## **Expected Publications**

Warren, A.E., et al. (2017) **Stakeholder perceptions in sub-Sahara Africa of private assistance for health and principles of aid effectiveness.**

Warren, A.E., et al. (2017) **The Global Fund's paradigm of oversight, monitoring, and results in Mozambique.**

Warren, A.E., et al. (2017) **Engaging with emerging economies for health development: a case-study of four sub-Sahara African countries**